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AMA submission – ACCC report to the Senate on private health insurance

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The AMA welcomes the opportunity to inform the ACCC about anti-competitive and other practices impacting on consumers and their medical practitioners.

We are pleased that the ACCC has chosen to focus this year on the transparency, accuracy and consistency of information provided by private health insurers and how this impacts on consumers' ability to make informed decisions about their insurance choices and subsequently any privately insured health care.

We have described the most common and serious problems below grouped in like categories, together with examples and suggestions for addressing them. Our submission is based on:

- specific responses received from AMA members in private practice to an email inviting them to contribute to this submission
- ongoing, issue-specific, unsolicited reports from members
- ongoing enquiries from members of the public seeking help and advice.

Patients not understanding their private health insurance policy

There is no doubt that there is a significant disconnect between most consumers' understanding, and therefore expectations, of the services and rebates they are entitled to under their private health insurance policy and the reality of what their product provides. Consumers often believe that longevity of membership with a health insurer entitles them to 'full cover' and that 'full cover' equates to 'no gaps'.

Some of the cause lies in a complex, and to most people unfathomable, public/private health care financing system. However, private health insurers produce poorly presented and/or confusing information, and it is frequently incorrectly explained by health insurance staff. The combined effect means that consumers have limited ability to 'shop around' and compare products, and to fully understand the products they have purchased.

It is usually only at the time when people need to have medical treatment in a hospital that they first comprehend that their insurance policy is deficient.

AMA members report that they often need to cancel booked procedures after it is realised that the patient is not covered, or does not have adequate cover, for the procedure. The most commonly cited procedures needing to be cancelled because of inadequate cover are cataract surgery, plastic and reconstructive surgery, and orthopaedic surgery.

This has considerable implications for patient care and treatment. It also impacts on the businesses of medical practitioners and private hospitals.

To minimise this, our members report needing to commit considerable time to help patients understand their policy, check with their insurer about the level and extent of their cover, and assist patients to challenge incorrect information provided by insurance staff.

> *Our staff spend approximately 8 hours a week conducting health cover checks for our patients*.
>
> *Doctors are doing health insurers' jobs for them. I shouldn't have to explain to patients the details of the cover they have purchased but it's necessary to run my practise.*

Hospitals carry a similar burden.

Our members report their patients do not fully understand how excesses, co-payments and waiting periods apply. However, the private health insurance products most commonly cited by our members as impacting on the care of their patients are products with exclusions or minimum benefits, and policies that are for treatment in public hospitals only. These are the details which are often only fully explained in the 'fine print' of hospital cover products.

Exclusion products

The most common complaints from AMA members result from private health insurance products with exclusions.

Our members report that the following exclusions resulted in the most problems for them and distress for their patients (listed in order of highest number of mentions):

- Cataract surgery
- Plastic and reconstructive surgery (related to skin cancers; hand, jaw or facial fractures; breast cancer)
- Hip and knee related orthopaedic surgery
- Psychiatric care
- Retinal surgery
- Renal failure/kidney disease related care
- Bariatric surgery
- Neurosurgery

Our members were universal in condemning the practice of selling policies with exclusions for procedures that are commonly required and the lack of clear explanation of the terms used.

Health funds market exclusion policies by saying 'you'll never need it so why use it?' But you can't predict what you will or won't need in the future. That's the whole point of insurance.

Patients think that an exclusion of 'plastic and reconstructive' surgery means 'cosmetic' surgery. Then they're shocked when they're not covered for specialist surgery to repair facial or hand fractures but would have been covered if they broke their shoulder.

My patients are shocked that they are covered for a procedure to remove a skin cancer lesion but not for necessary repair to the resulting defect.

In some cases, members are concerned that private health insurers are deliberately allowing members to take out or remain on a policy that is unlikely to suit their health needs.

I have patients over 60 with 'blue ribbon' or 'premium' cover finding they are not covered for cataract surgery. They are devastated after being members for 20 years or more. All policies sold to over 50s should have any exclusions 'signed off' every year.

When a patient transferred from her parents' cover to her own, she was sold a policy that excluded psychiatric care even though it was clear from her previous medical history that she had a chronic psychiatric condition.

They were also highly critical of marketing that leads consumers to select products with exclusions and failure to highlight to policy holders the changes that have been made to existing policies that exclude previously covered procedures.

Some of my patients were previously covered for specific procedures but did not understand the implications of being encouraged to take out a cheaper policy to reduce their premiums.

I've had patients who were told their premiums would not rise this year, but did not understand this had only happened because they had been shifted to a policy with exclusions; the detail was in the fine print.

Many members also described the difficulty for patients to find clear and accurate information about the extent of cover and likely gaps.

I can understand why my patients have no idea what their policy provides. When I checked the [health fund name] website description for its 'standard hospital' cover, it lists 'surgically implanted prostheses' as included, but only in later information does 'hip/knee replacement' show with a code 'MB'. Then you have to find out what that means, but the explanation only states 'minimum benefit'. You have to go to another webpage providing a 'detailed quote' to discover that 'minimum benefit' means it is 'likely to result in large out-of-pocket expenses'.

The elderly don't understand the fine print and the policy names are misleading.

Call centre staff of one health fund consistently advise my patients they are fully covered for rehabilitation in hospital but neglect to explain the cover is for a maximum of 14 days.

In our submission to the ACCC in 2010, the AMA proposed that all insurance products should cover procedures for which people expect to be covered such as heart surgery, knee and hip replacements, eye surgery, psychiatric care, rehabilitation and palliative care (as indicated by the results of a CHOICE survey cited in *Are you covered* CHOICE August 2010).

It is a concern therefore that the Private Health Insurance Administration Council data shows that the number of private health insurance policies with exclusions held by consumers has increased from around a third ten years ago to just under half today.

Private health insurers need to emphasise exclusions in their product information. Attached to this submission is a screen shot of a health insurer's website explanation of its basic hospital product. Under the heading *Hospital costs explained* it uses the cost of knee replacement to illustrate why having private health insurance is important. However, it is only at the very bottom of that webpage that consumers are advised that the product excludes hip and knee joint replacement surgery. The webpage layout is inconsistent with the Standard Information Statement (SIS) for the policy, which lists exclusions more prominently. The risk of course is that consumers will purchase the product without reading all of the webpage information or going to a separate page to read the SIS.

For existing policies that do have exclusions, these should be regularly explained by private health insurers and regularly acknowledged in some way by their members.

Our members also report cases where even health fund staff do not understand the nature of the exclusion policies.

> *One elderly lady had to retrospectively pay $7000 for hospital fees as her fund would not cover her for skin cancer related reconstructive surgery – retrospectively because the hospital had checked her cover with her health fund before the surgery and was told she was covered.*

Private health insurer front-line staff need to be adequately trained to understand and explain the policies they sell, and that patients hold.

<u>Policies covering public hospital care only</u>

This type of policy does not provide any value to patients. AMA member comments included:

> *Consumers are being sold a non-existent service because they wait the same amount of time for admission as public patients and they are usually unable to choose their doctor.*
>
> *In some states or regional areas it's completely useless because surgeons just can't offer that service.*
>
> *[This type of policy] should be outlawed.*

Given that these policies offer the lowest value of private health insurance benefit, the AMA considers they should no longer be available.

'Default' refusal to pay benefits for certain procedures

Under section 72-1 of the *Private Health Insurance Act 2007* (the PHI Act) private health insurers are required to pay benefits for hospital treatment for which a Medicare benefit is payable, subject to a health fund member having an up-to-date policy with no relevant exclusions.

AMA members report that some insurers take a virtually 'default' position of refusing certain claims. If the patient, with support from their doctor, complains and challenges the decision, the insurer eventually agrees to pay. This occurs most commonly with plastic and reconstructive surgery where the insurer considers the surgery is for purely cosmetic purposes.

> *My patients are typically refused payment from their insurer for medically required reconstructive surgery.*
>
> *The health funds refuse to pay, and then when challenged, delay payment for many months.*
>
> *They refuse to pay, then wait to see if the patient gives up or pursues the claim.*
>
> *My patient underwent rhinoseptoplasty for medical reasons after her fund assured her before the surgery that she was covered – my practice manager also checked with the fund – and now the fund is denying the claim saying it was cosmetic.*

The two largest private health insurers are circumventing their obligations under the PHI Act by rejecting the payment of private health insurance benefits prior to procedures being performed through newly introduced 'pre-approval' arrangements for certain plastic and reconstructive procedures. These arrangements require treating doctors to submit forms providing clinical details of the underlying medical condition, its severity and impact on the patient, and how the surgery will address the condition.

In a situation where the private health insurer refuses to pay, it is only the patient who has standing to pursue payment of the benefit through the courts. The reality is that few patients will do so and this seriously diminishes the value of the private health insurance product to consumers.

The AMA fully agrees that cosmetic services should not be paid for by the Government or private health insurers. It is working with the Department of Health on definitions for cosmetic services and plastic and reconstructive surgery to be included in legislation to reduce ambiguity about when a Medicare benefit, and therefore a private health insurance benefit, is payable. The additional requirements being imposed by Medibank and BUPA on medical practitioners and hospitals are therefore unnecessary.

Gaps, medical fees and rebates

Health funds don't explain the limits of the private health insurance policies being sold and instead leave it to medical practitioners at the point of consultations and hospitals at the point of admission to explain to patients why they will still have out-of-pocket costs.

Patients purchase polices named 'top cover' or 'premium', think they are fully covered, and are shocked at the gaps.

Health funds just tell patients that 'doctors are greedy' rather than explaining the limits of the insurance policy they are selling.

Consumers are also unaware that each private health insurer has its own schedule of benefits that it will pay for medical services and that the benefit paid to members for the same procedure varies between health insurers.

There should be a comparison table on a website of common procedures and what each insurer will pay. The variation between health funds can be huge. For example, if my anaesthetic fee for a 3 hour craniotomy for a tumour in NSW is $1500, my patient's out-of-pocket expense if they are a BUPA (known gap) member will be $10.50, for an NIB member $609.00, and a Medibank member $28.30. ASHA Fund members pay nothing extra.

[Health fund A] pays only a small rebate under no-gap schemes compared to [health fund B] but consumers have no way of researching this when purchasing their policy and this limits their choice of doctor.

The 'gap/known gap' arrangements for medical services and contracts with hospitals is not well understood by consumers. Consumers do not understand that unless the doctor accepts the insurer's schedule of medical benefit as their fee, or the hospital has a contract with the insurer, that the insurer is only required under the PHI Act to pay a minimum benefit amount. Unless they are prepared to pay large out-of-pocket costs their choice of doctor and/or hospital is limited. Again, this information is not easily accessible or comparable leading to significant inequities between patients claiming for the same procedure.

Patients don't understand that their health fund will only cover them in particular hospitals, even with the same doctor.

[Health fund name] pays gap cover for cardiac bypasses undertaken in some hospitals but not others, even if done by the same medical team.

It's unfair that if a doctor charges at the health fund's schedule fee the patient pays nothing extra, but if the doctor charges only $1 more the patient may pay $100s.

Some private health insurer activities in the pursuit of 'no gap' outcomes are also questionable.

[Health fund name] favours contracts with large, corporate owned hospitals rather than doctor owned hospitals which means that patients in regional areas have little or no choice.

Health funds are dictating the price at which a doctor's service is charged. If the doctor doesn't charge what the fund dictates, the patient is seriously penalised: it's like Samsung offering customers a cash back promotion on their new TV but only on the condition that Harvey Norman sells the product at a price determined by Samsung.

> *One of my patients who had to pay an out-of-pocket amount was told by [health fund name] that I had previously provided another patient with a no gap service and therefore she should ask to be charged the same way. This is a breach of commercial confidentiality.*

The AMA expects medical practitioners to advise patients what their fee is and if it is equal to the benefit that the patient's health insurer will pay. By the same token, the AMA expects health insurers to explain to their members that doctors are under no obligation to accept that benefit level, and if doctors don't, what level of benefit the insurer will pay.

Private health insurers should be required to publish their schedules of medical benefits in a way that is easily accessible to consumers and comparable with each other. As pointed out in previous submissions to the ACCC, this information is either not published or difficult to find on health insurers' websites.

In addition, a simple mechanism for highlighting the potential out-of-pocket costs to patients would be for each health insurer to annually publish the average out-of-pocket medical costs and hospital costs paid by their members for the most common procedures. This would help prompt health fund members to think about their potential costs, an appropriate level of cover, and again allow better comparison between health insurers.

Summary

The AMA acknowledges that the www.privatehealth.gov.au website and SISs for all policies offered by health insurers provides consumers with information about products and allows comparison between them.

However, ongoing consumer confusion demonstrates that people expect to be covered for the most common procedures, and often don't understand that, because of the policy they hold, they are not.

Private health insurers should take more responsibility for providing clear and accurate information so that consumers understand and acknowledge what their policy does cover. The health sector needs to work more collaboratively to assist people to understand how private health insurance covers the majority, but not always all, of the cost of health care and to ask the right questions of their insurer and healthcare providers.

Further, the majority of confusion and disappointment, and in some cases hardship, could be prevented by eliminating policies that exclude the very procedures for which patients expect to be covered, or that provide cover only for treatment in public hospitals.

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Choosing a higher excess will lower your premium. An excess will apply to each adult member admitted to hospital per calendar year. No hospital excess applies to children on family memberships.

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Hospital costs: what we pay for ^

Hospital costs explained

Hospital cover helps with the cost of treatments in hospital as a private patient, and includes ambulance transportation when you need immediate professional attention and your medial condition means you can't be transported in any other way.

$8,147 for childbirth and $22,955 for knee replacement surgery: These are just two common procedures and their costs in a private hospital if you don't' have private health insurance.

(Figures are an average of Medibank's claims information in 2012)

Benefits we pay

For the services included under each of our covers, we'll pay benefits (less than applicable excess) towards:

- ✓ eligible ambulance services
- ✓ overnight accommodation in a private hospital or shared room accommodation in a public hospital as a private patient
- ✓ same-day admission
- ✓ theatre fees
- ✓ intensive care

Benefits we don't pay

- × Some high-cost medications
- × Services not covered by Medicare
- × Prostheses in excess of approved benefits in the Government's Prostheses List
- × Cosmetic treatment is excluded on all Medibank

covers.

Call us on 134 190 before you go to hospital to understand exactly what you're covered for.

Included	Treatments & Features	Waiting periods
✓	**No Excess for kids on a family membership** No matter what hospital excess you pay, the excess will not apply if kids on your membership are admitted to hospital	2 months (12 months for pre-existing conditions)
✓	**Ambulance services** 100% cover for immediate professional attention. Includes ambulance transportation to hospital when your medical condition means you can't be transported in any other way.	2 months
✓	**Shoulder and knee reconstruction surgery & investigations** Reconstructions to repair ligament tears, remove loose tissue or treat other damage	2 months (12 months for pre-existing)
✓	**Appendicitis treatment** Hospitalisation for appendicitis	2 months (12 months for pre-existing)

✓	**Removal of appendix** The surgical removal of your appendix	2 months (12 months for pre-existing)
✓	**Removal of tonsils & adenoids** Surgery to remove tonsils and/or adenoids	2 months (12 months for pre-existing)
✓	**Surgical removal of wisdom teeth (for hospital charges only)** Accommodation and theatre charges for wisdom tooth removal in hospital (does not include doctor/dentist fees)	2 months (12 months for pre-existing)
✓	**Colonoscopies** Procedure to examine the large bowel	2 months (12 months for pre-existing)
✓	**Palliative care** Health care that provides support to people with a life-limiting illness	2 months
Restricted ⓘ	**Psychiatric treatment** Including diagnosed disorders or addiction requiring immediate hospital-based intervention	2 months
Restricted ⓘ	**Rehabilitation treatment** Approved physical therapy and exercise programs, generally	2 months

	following an inpatient admission	
✓	All other joint replacement surgery Replacement surgery for shoulders, elbows and ankles	2 months (12 months for pre-existing)
✓	Other in-hospital services where a Medicare benefit is payable The Medicare Benefits Schedule defines what are considered appropriate interventions or treatment in Australia. For further details, including services that are excluded from this cover, please email this quote (via the Email quote button on this page).	2 months (12 months for pre-existing)
✓	Access to Mi Health support services (24/7 Health Advice Line, Hospital Support, Health Hub, Mobile Health Apps) Medibank nurse 24/7, Online Health Hub, mobile health apps	nil

Services not covered by this product:

- ✕ Heart-related services
- ✕ Obstetrics-related services (eg. pregnancy)
- ✕ Fertility treatment (eg. IVF & GIFT programs)
- ✕ Plastic & reconstructive surgery
- ✕ Major eye surgery - including cataract & lens-related services
- ✕ Hip & knee joint replacement surgery

- ✕ Renal dialysis
- ✕ Accident benefit
- ✕ Private hospital room priority
- ✕ Ultra Bonus (for out-of-pocket-expenses)

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Help cover the cost of extras with extra cover that suits you

BASIC EXTRAS

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$6.42
/week
($12.84 per fortnight)

⊕Add

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from
$9.79
/week
($19.58 per fortnight)

⊕Add

Private Health Insurance Standard Information Statement - Hospital Policy

This Statement provides basic information for the purposes of comparison only. **For full explanation of this hospital policy please contact the health insurer** on 134190 or visit http://medibank.com.au.

HEALTH INSURER:	**Medibank Private Limited**	WHO IS COVERED:	**Two adults & dependant(s)**
PRODUCT NAME:	**Basic Hospital $250 Excess**	MONTHLY PREMIUM: #	**$203.10** (before any rebate or loading)
AVAILABLE FOR:	Residents of **NSW & ACT**	MEDICARE LEVY SURCHARGE:	**Exempt**

You may be entitled to an Australian Government rebate on this premium. Your premium may include a Lifetime Health Cover loading and/or an insurer discount depending on your individual circumstances. Check with your insurer for more details.

WHAT'S COVERED IF I HAVE TO GO TO HOSPITAL?	✓ Hospital treatment, including accommodation as a private patient in a private or public hospital ✓ Doctors' bills in hospital (see below) ✓ Comprehensive cover for ambulance (see insurer for details) - 2 months waiting period applies
WHAT SERVICES ARE NOT COVERED AT ALL? (Exclusions)	✗ Cardiac and cardiac related services ✗ Cataract and eye lens procedures ✗ Pregnancy and birth related services ✗ Assisted reproductive services ✗ Hip and knee replacements ✗ Dialysis for chronic renal failure ✗ Non-cosmetic plastic surgery ✗ Hospital treatment for which Medicare pays no benefit eg most cosmetic surgery
WHAT SERVICES ARE ONLY COVERED TO A LIMITED EXTENT? (Restrictions, Benefit Limitation Periods)	You are not fully covered for: • Rehabilitation • Psychiatric services *No benefit limitation periods*
HOW LONG ARE THE WAITING PERIODS FOR NEW AND UPGRADING MEMBERS?	• 2 months for palliative care, rehabilitation and psychiatric treatment • 12 months for treatments relating to other pre-existing ailments • 2 months for all other treatments
WILL I HAVE TO PAY ANYTHING IF I GO TO HOSPITAL? (Excesses, Co-payments, Medical/Hospital gaps)	**EXCESS:** You will have to pay an excess of $250 per admission. This is limited to a maximum of $250 per person per year. Excess payments do not apply to hospital admissions for dependants. **EXTRA COST PER DAY** (CO-PAYMENTS): No co-payments **DOCTORS' AND HOSPITAL BILLS:** 9 out of 10 medical services paid for by this health insurer in NSW & ACT have no out-of-pocket expenses. This insurer also has arrangements that may mean lower out-of-pocket expenses on doctors' bills. You may also have to pay other costs depending upon: • the doctor(s) chosen • the treatment you are having • the hospital you go to **Before you go to hospital, you should ask your doctor, hospital and health insurer about any out-of-pocket costs that may apply to you.**
WHAT OTHER FEATURES DOES THIS POLICY HAVE?	Basic hospital cover. Provides cover for most hospital services young and healthy people are likely to need. No excess for Children. Access to Mi Health, a range of health support services including Medibank nurses 24 hours, 7 days a week to answer any health question you may have.