VALUE AND AFFORDABILITY OF PRIVATE HEALTH INSURANCE AND OUT-OF-POCKET MEDICAL COSTS

ADIA SUBMISSION

August 2017

ADIA is grateful for the opportunity to provide a submission to the Senate Standing Committee on Community Affairs Inquiry, and would welcome the opportunity to participate in a public hearing.

About ADIA

ADIA represents radiology practices throughout Australia, both in the community and in hospitals. It promotes the ongoing development of quality accreditation standards and appropriate funding settings so that Australians can have affordable access to quality radiology services. This supports radiology's central role in the diagnosis, treatment and management of a broad range of conditions in every branch of medicine.

Funding of radiology under Medicare

In 2015-16, 24.7 million radiology services – including x-ray, ultrasound, CT, nuclear medicine and MRI scans – were provided under Medicare, with the Australian Government investing $3.2 billion in patient rebates:

- 22.8 million services were provided to outpatients
- 1.9 million services were provided to inpatients

Patient rebates for radiology have been frozen since 1998, and radiology now has the highest upfront and highest out of pocket costs among primary care services, and the lowest bulk billing rates:

Medicare statistics for out of hospital primary care services, 2015-16[1]

	General practice	Pathology	Radiology
Bulk billing rate	85.4%	99.0%	**83.5%**
Average patient gap	$34.24	$25.01	**$97.34**
Average upfront cost	$79.49	$44.73	**$217.33**

The freeze means that the Government's contribution to radiology services is flat, while the contribution made by patients increases every year. Radiology is currently the greatest barrier to quality primary care in Australia, and patient gaps are estimated to double over the next decade unless the Government ends the rebate freeze.

[1] ADIA analysis of Medicare statistics, Financial Year 2015-16

The Government broke its promise to index Medicare rebates for radiology

During the 2016 election campaign, the Turnbull Government promised to index Medicare patient rebates for radiology when the GP rebate freeze ended:

> "*The Coalition will ensure that diagnostic imaging indexation resumes when the current GP rebate indexation freeze concludes.*"[2]

This commitment was welcomed by ADIA, as it recognised the need to end the indexation freeze which has lasted almost two decades and has significantly undermined patient care. Indexation is critical to ensure that quality radiology services are accessible and affordable for all Australians.

In the 2017-18 Budget, the Government announced that it will index GP consultations from 1 July 2018. However, the Government did not meet its commitment to index radiology services on the same date, announcing instead that it will index only 59 of 891 radiology items on the Medicare Benefits Schedule.

Indexing only 7% of radiology items represents a clear breach of the Government's election commitment, and will do little to improve access to lifesaving radiology services. Despite the Government's rhetoric that it is 'guaranteeing Medicare'', access to radiology under Medicare is not guaranteed for Australian patients.

[2] https://www.liberal.org.au/latest-news/2016/06/05/coalition-plan-access-affordable-diagnostic-imaging-all-australians

Recommendations

Recommendation 1
To protect patients from needing to pay hundreds or thousands of dollars to access radiology, the Government should amend Medicare rules and systems to allow patients to pay just the gap upfront through a HICAPS-style billing system.

Recommendation 2
The Government should meet its 2016 election commitment by reinstating indexation of all radiology services in line with GP services on 1 July 2018.

Recommendation 3
Private health insurers should fund all referred radiology services, including clinically recommended services that are not listed on the MBS. This includes MRI services provided on unfunded or partially funded MRI units.

Recommendation 4
The guiding principle that the Medical Services Advisory Committee uses to determine its recommendations to Government should be that services referred for at arm's length in significant volumes (i.e. have become 'standard of care') should be listed on the MBS and available to all Australians – not just those who can afford private fees.

Recommendation 5
Fees paid by private health insurers should reflect the higher costs associated with providing radiology in a comprehensive hospital setting.

Recommendation 6
Private health insurers should increase fees paid to radiology providers annually, to ensure that fees keep pace with rising costs. This would reduce out of pocket costs for patients, who do not expect to pay gaps when they purchase private health insurance.

The effect of co-payments and medical gaps on financial and health outcomes

The average gap for Medicare radiology services is almost $100

Gaps for radiology services averaged $97 in 2015-16, with patients contributing over $500 million to the cost of Medicare-eligible services. For complex services like CT, MRI and PET, the average is well over $150.

In addition, where a Medicare service is not bulk billed (i.e. the patient is charged a gap), the patient needs to pay the full cost of the service upfront before they can claim the rebate. For high-cost services like radiology, upfront costs can be several hundreds of dollars per service – another barrier to access for Australian patients.

Average gaps and upfront costs, 2015-16[3]

	Ultrasound	CT	X-ray	NM	MRI	Total
Average gap	$106	$150	$52	$105	$184	**$97**
Average upfront cost	$211	$439	$101	$469	$543	**$217**

Due to the Medicare rebate freeze, average gaps for radiology almost doubled between in the decade to 2015-16 (from $51.54 in 2005-06 to $97.34 in 2015-16).[4]

Recommendation 1
To protect patients from needing to pay hundreds or thousands of dollars to access radiology, the Government should amend Medicare rules and systems to allow patients to pay just the gap upfront through a HICAPS-style billing system.

Medicare is a two-tiered system in which many Australians can't afford the radiology they need

The Australian Bureau of Statistics found that almost 300,000 patients, delayed or did not have an imaging service recommended by their doctor in the last twelve months:

Whether delayed having or did not have an imaging test because of cost in the last 12 months[5]

	15-34	35-64	65+	Total
Delayed or did not have an imaging test because of cost	96,200	156,300	22,400	**277,300**

The Medicare Safety Net is designed to assist patients who encounter high out-of-pocket costs, but because most radiology services occur early in the patient journey, many Australians who need radiology haven't reached the Safety Net threshold when they have the service.

[3] Medicare Statistics provided by the Department of Health
[4] Medicare statistics provided by the Department of Health
[5] ABS (2016), *Patient experiences 2015-16: Customised report*

Private health insurance product design, including product exclusions and benefit levels

While private health insurers have increased premiums by an average 5.60% each year in the last eight years,[6] this revenue is not being returned to patients through increased funding for radiology services.

Instead, the opposite is happening. Several insurers have reduced the fees they pay for radiology when agreements with providers expire. These agreements have not been renewed or have been renewed at lower fees, resulting in more patients paying gaps for in-hospital services. In many cases patients are not aware that their level of cover is effectively reduced (i.e. a shift from not paying a gap to paying a gap) until they are invoiced upon discharge from hospital.

See attached articles:

- 'Medibank's secret cuts to rebates for scans and blood tests leaves members hundreds of dollars out of pocket'
- 'Medibank accused of concealing policy changes to pump up profits before sale: ACCC'

The role and function of medical pricing schedules, including the Medicare Benefits Schedule, the Australian Medical Association fee schedule and private health insurers' fee schedules

Medicare Benefits Schedule rebates for radiology have been frozen since 1998

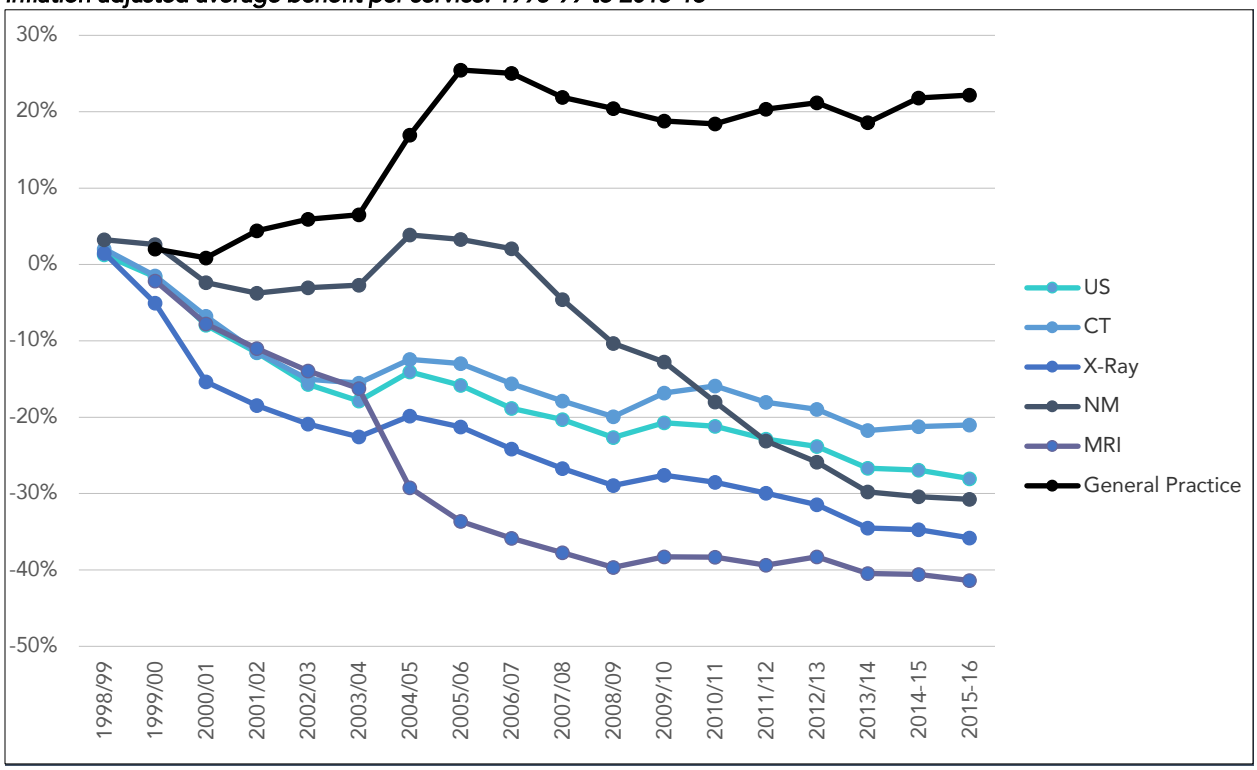
Most fees paid by private health insurers to radiology providers are based on Medicare Benefits Schedule fees. With Medicare fees frozen, this means that in-hospital fees are also frozen, and do not keep pace with the increasing cost of delivering quality services:

- Labour is the largest cost component in a radiology service, with around 60% of service costs covering radiologists (who are medical specialists), allied health professionals and administration staff
- Capital costs account for 20% of the cost of a radiology service
- Other costs include medical supplies, rent, electricity and IT

The real impact of the indexation freeze has been an effective cut to patient rebates for radiology every year. On a modality basis, average patient rebates per service have fallen by between 21 per cent (CT) and 41 per cent (MRI) in real terms, compared to average rebates for GP services which increased by 22 per cent over the same period.

[6] *http://health.gov.au/internet/main/publishing.nsf/content/privatehealth-average-premium-round*

Inflation adjusted average benefit per service: 1998-99 to 2015-16[7]



In real terms, since the rebate freeze began the Government's contribution to the cost of each radiology service has fallen from 73 per cent to 57 per cent. Patients are forced to make up the shortfall, with gaps almost trebling from 1998 to now.

Average patient rebates and gaps[8]

	1998-99	2015-16
Average patient rebate (Government contribution)	$93.58	$130.90*
Average gap (patient contribution)	$33.96	$97.34
Government contribution to each service	73%	57%

*Increase in average patient rebate is due to increasing use of complex services

[7] ADIA analysis of statistics provided by the Department of Health; ABS data

[8] ADIA analysis of statistics provided by the Department of Health

The impact of the freeze can be seen on the following items, most of which have lower rebates today than in 1998:

Service	1998 rebate	2017 rebate	Variation	Fall in real value
Ultrasound: vascular	$147.00	$144.10	↓ $2.90	↓ 39%
Ultrasound: interventional procedure	$86.70	$92.75	↑ $6.05	↓ 34%
CT: chest, abdomen and pelvis	$528.85	$480.50	↓ $48.75	↓ 44%
CT: brain	$218.70	$212.50	↓ $6.20	↓ 40%
X-ray: skull	$58.65	$54.85	↓ $3.80	↓ 42%
MRI: scan of head for stroke	$424.60	$342.75	↓ $81.85	↓ 50%
MRI: scan of musculoskeletal system for infection	$424.60	$323.70	↓ $100.90	↓ 53%

Recommendation 2
The Government should meet its 2016 election commitment by reinstating indexation of all radiology services in line with GP services on 1 July 2018.

Medicare doesn't cover all radiology services

Medicare has not kept pace with technological advances in radiology because the MSAC process imposes very high hurdles for services to be listed on the MBS.

Services not funded by Medicare (and therefore privately funded by patients) include:

- Most GP-referred MRI examinations
- mpMRI prostate diagnostic scans and MR-guided prostate biopsies
- PSMA PET/CT scan for prostate cancer
- MRI scan for evaluation of breast cancer
- FDG PET scan for pancreatic cancer
- CT coronary artery calcium scoring
- MRI scans provided on unfunded or partially funded MRI units

The shortcomings in the range of services funded by Medicare affects privately insured patients, because private health insurance coverage is generally limited to services listed on the MBS. This means that, for example, the 10-15% of patients with breast cancer who are referred for MRI prior to surgery must fund that service themselves (around $600) even where they have private health insurance.

Recommendation 3
Private health insurers should fund all referred radiology services, including clinically recommended services that are not listed on the MBS. This includes MRI services provided on unfunded or partially funded MRI units.

Recommendation 4
The guiding principle that MSAC uses to determine its recommendations to Government should be that services referred for at arm's length in significant volumes (i.e. have become 'standard of care') should be listed on the MBS and available to all Australians – not just those who can afford private fees.

Radiology services in hospital are more expensive to provide than in community practices

Due to the nature of the work and the expectations of providing radiology in a comprehensive hospital setting, the cost of providing the service is significantly greater than when compared to offering radiology services in a community setting. Further detail on these cost pressures is provided at Appendix A.

Recommendation 5
Fees paid by private health insurers should reflect the higher costs associated with providing radiology in a comprehensive hospital setting.

Recommendation 6
Private health insurers should increase fees paid to radiology providers annually, to ensure that fees keep pace with rising costs. This would reduce out of pocket costs for patients, who do not expect to pay gaps when they purchase private health insurance.

Inconsistency in private health insurers' fee schedules

Hospital-based radiology providers negotiate individual fee agreements with each private health insurer. This is usually based on a percentage of the Medicare Benefits Schedule fee, and can be:

- 'No gap agreements', where the provider does not charge patients a gap
- 'Known gap agreements', where gaps are limited (for example, to a total of $500 per admission or a gap of $100 per procedure)
- An agreement without reference to the gaps that the provider charges patients

Unlike for Medicare where the Department of Human Services has one funding agreement in place with all radiology providers, a typical radiology provider would have dozens of separate agreements.

In cases where a radiology provider does not reach agreement with an insurer, the insurer unilaterally sets the fees for radiology services, and the provider usually charges a gap to patients.

APPENDIX A
Radiology services in hospital are more expensive to provide than in the community

- The cost of labour within a comprehensive hospital radiology department is higher, due to:
    - The nature of care required outside ordinary working hours, with after hours and on-call required. Additional hours outside the ordinary working day can be 'less productive' but also come at a higher cost due to overtime and penalty rates, on-call allowances and other allowances
    - Additional radiology resources are required to cover a wider range of sub-specialties, coordinate multi-disciplinary meetings and provide complex interventional procedures. In addition, patient condition and type are generally significantly more difficult than in a community setting, which requires more labour
    - Additional technical staff are required to cover a wider range of modalities, including services unique to hospital environment (such as in-theatre and mobile in-ward radiography)
    - Additional radiology support staff such as nurses and orderlies are required
    - Staff are generally paid at a higher rate in hospital-based practices due to higher level of skill required for the hospital workload
    - Practices are usually required to participate in hospital training and committees

- The cost structure of a comprehensive radiology practice in a hospital setting includes requirements not applicable in community practices:
    - Requirements for short turn-around times in bookings and reporting, after hours requirements, service offerings etc., under strict Service Level Agreement (SLAs). This requires additional staff, as well as increased requirements for support services such as typing and IT
    - Participation in multi-disciplinary and other clinical meetings. These are often hosted by the radiology practice and not only require significant radiologist time but also technical staff input for collation and importing of results. In addition, increased referrer and hospital staff interaction is required
    - Integration between radiology and hospital systems which requires significant ICT resources and costs. This includes integration of phone systems, image delivery to theatres and wards, risk management systems, and report delivery systems
    - The equipment required within a hospital setting is usually high end, advanced equipment, which means higher capital costs and maintenance costs (due to up-time requirements and the need for after-hours servicing)
    - The expectation that the practice purchase, maintain and perform unprofitable modalities and examinations

- Rent and outgoings are significantly higher in a hospital setting. Space requirements are more than 50% higher than in a large, fully comprehensive community site because of minimum corridor size, trolley bay spaces, and the requirement to provide additional modalities. ADIA estimates that the cost per square metre of fitting out a hospital practice is typically more than 70% higher than a large, fully comprehensive community site).

- Medical supplies are significantly more expensive than in community practices due to the nature and complexity of procedural cases.

Medibank's secret cuts to rebates for scans and blood tests leaves members hundreds of dollars out of pocket

NOVEMBER 25, 20146:34PM

Secret cuts...Medibank members could face gap fees of hundreds of dollars for CAT scans after the fund cut its rebates. Picture: Thinkstock

Sue Dunlevy National Health Reporter

News Corp Australia Network

MEDIBANK members have profited on the stock market but if they use their health insurance they'll now be hundreds of dollars out of pocket as a result of a secret cut to benefits.

Medibank slashed the amount it will pay for X-rays, MRIs and other tests on September 1.

The fund has not informed its members of the policy change in writing and they will only find out when they get the bill or if they ring the fund before they go to hospital.

"We supply policyholders with written information on what to expect with their hospital visit, when we know they have an upcoming hospital experience," a Medibank spokeswoman said.

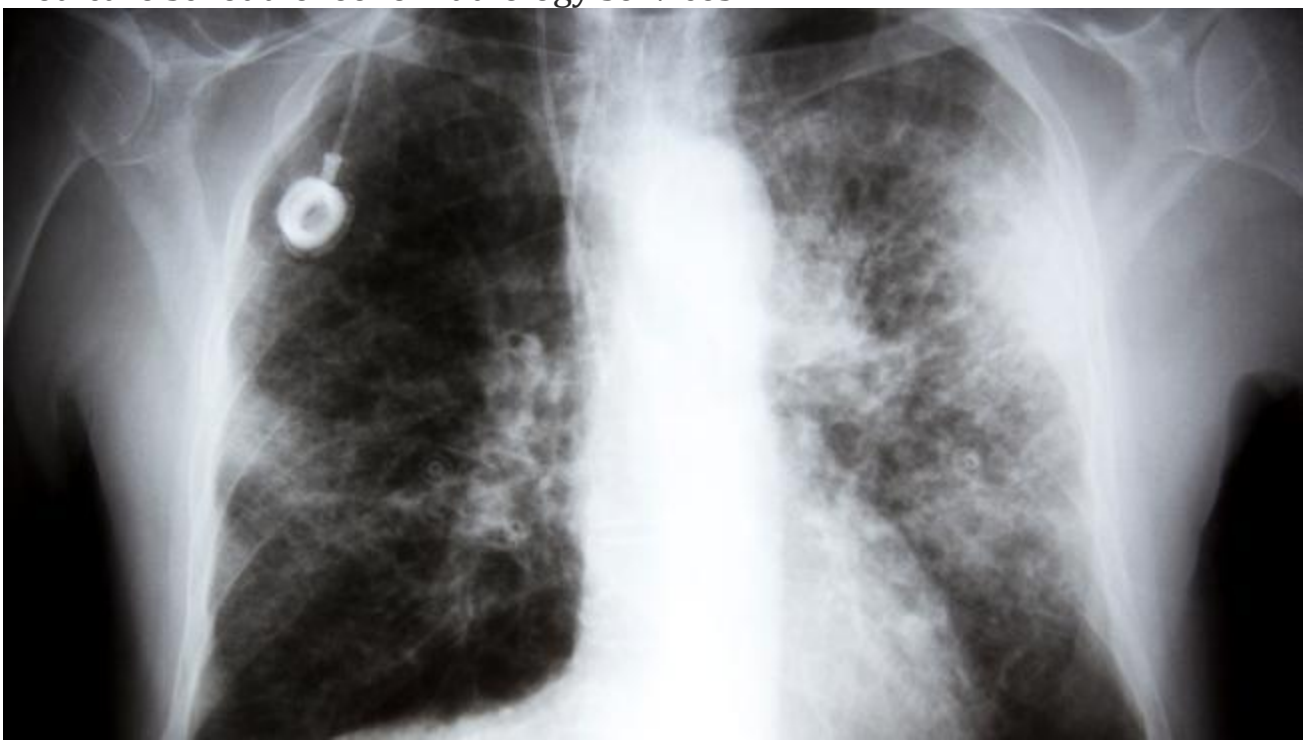
Taking a second look...Medibank conducted a review of pathology and radiology costs and cut benefits. Picture: Eiszele Kim.
Source:*Supplied*

The fund's stance, ahead of its sensitive listing on the stock exchange this week, might save it money but could be in breach of health fund rules.

A spokesman for Private Health Insurance Ombudsman Samantha Gavel says she "regularly talks about funds informing their members in writing of changes to policies,".

However, this change may fall outside this provision if it is regarded as a change to a purchaser provider agreement rather than a change to the policy itself.

The nation's largest health fund says from September 1 it will only pay the Medicare schedule fee for radiology services.



Secret cuts...X-rays and other scans could cost patients more as a result of Medibanks rebate cuts. Picture muratseyit. Source:*Supplied*

This fee can be up to 30 per cent less than what providers charge.

A review by the fund found pathology and radiology benefit payments were rising well ahead of Medicare Benefits Schedule increases, the fund says.

"In the past we contracted with several large pathology and radiology providers at set fees. Unfortunately, these fees were rising well ahead of the Medicare Benefits Schedule of fees," Dr Andrew Wilson, Medibank Executive Manager of Provider Networks & Integrated Care.

"If we continued to pay pathology and radiology benefits in line with current trends, we believe it would have an adverse impact on premiums and the affordability of private health insurance," he said.

The fund concedes “as a result there may be out-of-pocket costs for policyholders”.

For example it says some companies are charging $516 for a CAT scan of the abdomen, Medibank will now be providing its members with a rebate of just $385 leaving them $131 out of pocket.

Australian Medical Association president Associate Professor Brian Owler attacked Medibank over the changes claiming they were only too willing to highlight patient gaps resulting from doctors fees “but not the out of pocket costs they are creating,” he said.

Impossible...AMA President, Associate Professor Brian Owler says doctors can’t get quotes from radiology providers before they order a scan. Picture: Supplied.Source:*News Corp Australia*

Dr Owler said it was not possible for doctors to inform patients what the gap fees for scans or tests might be because they would not know what fees providers charged.

“It’s impossible to expect the doctor every time they order a test to get quotes on whether a blood test costs x or y or z,” he said.

“We order them on the basis of clinical need, not on the basis of what the out of pocket cost will be for a Medibank patient,” he said.
Consumers Health Forum chief Adam Stankevicius said Medibank was treating its members “like bunnies”.

“It has slugged members with above average premium increases for the past two years yet now members find they will have to cover gap charges that can run into hundreds of dollars for radiology and pathology,” says CHF CEO Adam Stankevicius.

“These are the sort of “surprise” gap charges that Tony Abbott promised to curtail when he was Health Minister.

“This is a disturbing start to Medibank’s new status as a publicly listed company. Medibank should be upfront when it downgrades its cover. After paying for a 6.49 per cent premium rise earlier this year consumers have a right to be warned that their insurance cover is actually shrinking,” he said.

Australian Private Hospital’s Association chief Michael Roff says the Medibank move is “concerning”.

“Anything that funds do to increase gaps undermines the value proposition of private health insurance,” Mr Roff said.

“At the same time as they are entering contracts with hospitals to eliminate medical gaps, here they are increasing gaps as part of a service.

Source:
http://www.news.com.au/news/medibanks-secret-cuts-to-rebates-for-scans-and-blood-tests-leaves-members-hundreds-of-dollars-out-of-pocket/news-story/1227134789373

The Sydney Morning Herald

Medibank accused of cor policy changes to pump before sale: ACCC

Esther Han

Australia's biggest health insurer has been accused of concealing policy changes - which left patients with large, unexpected bills - as part of its attempt to boost profits ahead of its privatisation.

The Australian Competition and Consumer Commission has hauled Medibank before the Federal Court, saying it engaged in misleading and unconscionable conduct by failing to notify policyholders it had slashed coverage of common hospital tests such as X-rays, CT scans and blood tests.

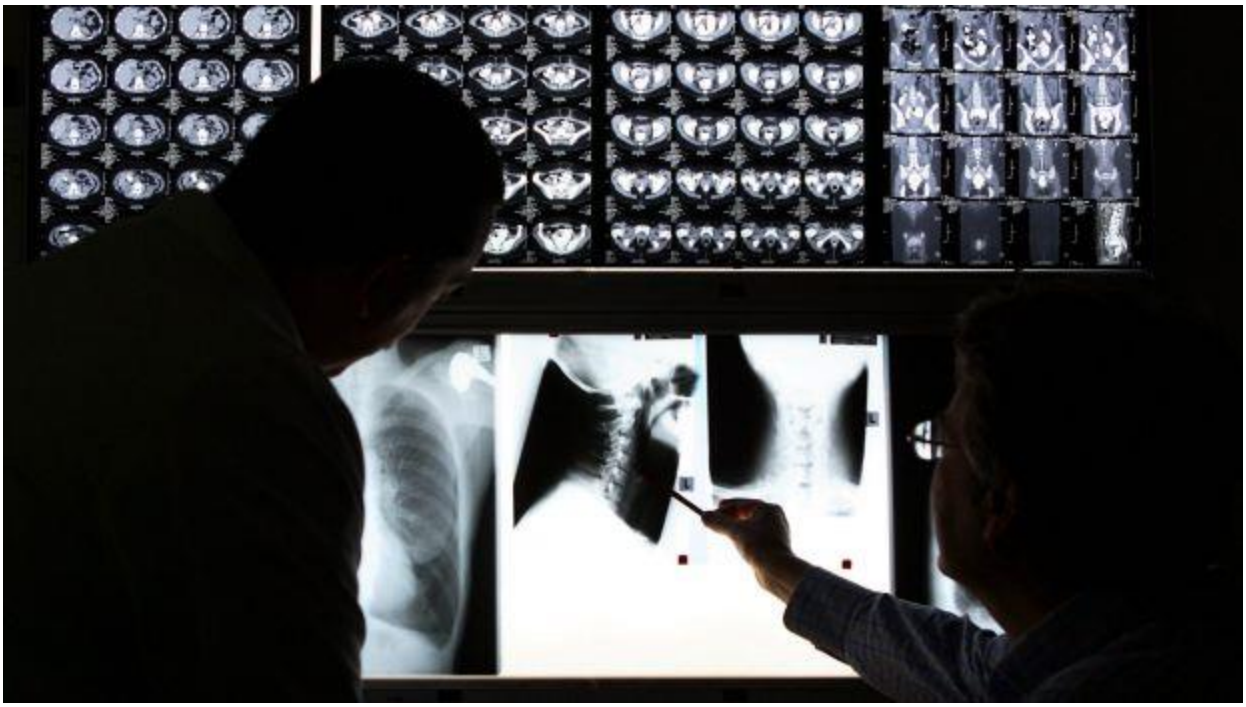
On average, affected members were hit with an out-of-pocket expense of $151 for pathology and $83 for radiology, court filings show. Fairfax Media is aware of one patient left with a shock $1500 bill.

Medibank has been taken to the Federal Court by the ACCC. Photo: Glenn Hunt

The watchdog alleges Medibank kept quiet about the policy change, made in September 2014, to prevent a customer exodus and boost profits ahead of a $5.7 billion public float, which occurred two months later.

Finance Minister Mathias Cormann, who spearheaded the sale, said he wasn't aware of the alleged misconduct and pointed out the ACCC was consulted as part of the due diligence process.

"The commonwealth was the vendor and received all of the proceeds from the IPO on behalf of taxpayers. Medibank, including its board and management, were not the beneficiary of any of the IPO proceeds."



Under the secret policy changes, Medibank policyholders had to pay the gap for in-hospital services such as blood tests, X-rays, CT scans and MRI scans Photo: Jessica Shapiro

Labor said if the allegations are proven true, it showed privatisation did not benefit the health system or policyholders.

"[It's a] stark reminder of the danger to patients if the Turnbull Government is re-elected and continues to press ahead with its plans to privatise Medicare, putting profits before patients," said Opposition health spokeswoman Catherine King.

Phyllis Dixon is fighting fees because of changes to her Medibank private health insurance. Photo: Eddie Jim

"Given Mr Cormann was the responsible minister for the 100 per cent shareholder, it strains credulity he now argues he had no knowledge of this incident," Ms King's spokesman added.

Health Minister Sussan Ley refused to comment on the court proceedings, but said the legal action highlighted the need for transparency in the health insurance sector.

 ACCC chairman Rod Sims.Photo: Nic Walker

"That's why Bill Shorten and Labor's flippant dismissal of the Coalition's plan to shine a light on fine print and introduce standard levels of cover is an insult to the 12 million Australians with private health insurance."

The ACCC alleges Medibank also calculated it stood to make big profits because it wouldn't have to pay gaps or the future medical claims of members who left because of the change but were likely to make claims frequently.

"The [initial public offering] was a very relevant background factor, so one can draw inferences. Certainly it makes logical sense this is the time when you're trying to maximise your earnings," said ACCC's chairman Rod Sims.

Medibank rejects claims

A Medibank spokesman said the health fund, which has 3.9 million members through its Medibank flagship and subsidiary ahm brands, refuted the ACCC's claims.

Its share price tumbled nearly 5.5 per cent on the stock exchange, while the broader market was steady.

"Medibank takes its obligations under the Australian Consumer Law seriously, and has appropriate processes in place to ensure compliance. We have been working co-operatively with the ACCC throughout its investigation," the spokesman said.

The ACCC said the alleged misconduct impacted most hospital policies in place since January 2012.

Since that time, Medibank had agreements with in-hospital pathology and radiology providers, where it would cover the gap on behalf of members if the providers charged above the Medicare Benefit Schedule fee.

Court documents show in September 2014, Medibank terminated or phased out the agreements. As a result, policyholders were no longer completely covered, and had to pay the gap as an out-of-pocket expense.

"Medibank has made no changes in response and the conduct is continuing," said Mr Sims. "We believe there were many people affected and urge them to complain to Medibank in the short-term."

Show me the money

The ACCC wants Medibank to reimburse affected members for any out-of-pocket expenses since September 2014.

It alleges Medibank only forked out "ad hoc payments" when members, outraged by the change, complained.

Medibank policyholder Phyllis Dixon told Fairfax Media last year she was shocked with a $1500 bill from a diagnostic imaging companyshortly after she was discharged from a private hospital in Melbourne.
Her daughter Gail Robins-Browne said: "My mother has on file many letters from Medibank Private informing her of other changes to premiums and the cover provided, but they seem to feel that it was not necessary to inform their clients of this very significant change."

At the time the Private Health Insurance Ombudsman said about 30 people had complained about the same issue and that all complaints had been resolved by Medibank without requiring further investigation by the ombudsman.

Consumer confusion

The ACCC alleges Medibank exploited consumer confusion in regards to the health insurance system.
As a signatory of the Private Health Insurance Code of Conduct, Medibank should have given its members advanced notice of "detrimental changes". It also did not update it marketing and product summary materials.

It said Medibank knew or expected that many members incorrectly assumed their in-hospital medical expenses were covered, and that most members didn't make enquiries about out-of-pocket expenses before being admitted to hospital.

"[Consumers] have significantly lower bargaining power ... poor familiarity with private health insurance policy terms ... relied on Medibank to inform them about their entitlements to benefits and about potential out-of-pocket expenses," the court filings show.

It said Medibank ought to have known the biggest impact would be on a "vulnerable class of consumers", because they were likely to have been previously hospitalised and/or had chronic conditions requiring frequent admissions to hospital.

It alleges the health fund adopted a strategy of keeping communications about this change "contained and reactive".

The Consumer Health Forum said the court action highlighted the need for reforms to make health insurance simpler, transparent and more certain for consumers.

"We need to provide an effective incentive for funds to provide genuine, consumer-friendly policy documents that people can understand and rely on," said the forum's chief executive Leanne Wells.

The legal action comes just months after Medibank reported a surge in profit for the first half of 2015-16 of $271.7 million, up nearly 60 per cent in one year.

The ACCC is seeking declarations, injunctions, compensation orders, pecuniary penalties, findings of fact, implementation of a trade practices compliance program, corrective notices and costs.

Source:
http://www.smh.com.au/business/consumer-affairs/medibank-accused-of-concealing-policy-changes-so-members-wouldnt-leave-accc-20160615-gpk555.html