Day Hospitals
AUSTRALIA

9 March 2017

Mr David Salisbury
General Manager
Consumer & Small Business Strategies Branch
Australian Competition & Consumer Commission
GPO Box 520
MELBOURNE VIC 3001
(submitted via phireport@accc.gov.au)

Dear Mr Salisbury

ACCC REPORT TO THE SENATE ON PRIVATE HEALTH INSURANCE

Day Hospitals Australia (previously known as the Australian Day Hospital Association) is the peak industry body representing over two thirds of the private standalone day hospital sector across Australia. The opportunity to contribute to the Australian Competition and Consumer Commission's annual report to the Senate on changes that health insurers have made regarding information to consumers is appreciated.

The notation regarding the Private Health Ministerial Advisory Committee is acknowledged. Day Hospitals Australia advises that it is an active participant on this committee.

This submission will address the points raised in your correspondence relating to market Issues and trends and health insurers provision of information to consumers.

Market issues and Trends

There has been a continuation of the trend, by the major health insurers, not to contract with new private day hospitals and smaller private hospitals.

This has resulted in the impacted private hospitals having to rely on the Second Tier Default Benefit in order to provide services to privately insured consumers. This may result in the consumer being charged an out of pocket expense in the form of a gap payment, which allows the hospital to cover the cost of the patient's treatment or procedure.

This trend can also influence the amount of choice that the consumer has in the private hospital sector.

In a recent survey of members of Day Hospitals Australia it was reported that 54% of the 120 respondents indicated that they did not have contracts with all health insurance funds which impacted their business.

Several day hospitals have reported that some health insurance funds are not providing Second Tier Default Benefit rates for oral surgery and dental procedures. This has an impact on consumers, who then can experience significant out of pocket expenses due to lack of Second Tier Default Benefits available for these services. Funds do not appear to have communicated this significant change to their members. There also appears to be a trend in many of the larger private hospitals not to offer such services due to poor health insurance rates, so this treatment is being undertaken more and more in the standalone day hospital sector, a percentage of whom rely on Second Tier Default Benefits, particularly in relation to the larger health funds.

Feedback from members would indicate that Second Tier rates are still being manipulated, as reported last year. Some hospital contracts still contain services not provided by the individual hospital. This practice has the potential to distort rates, would seem to be a misuse of market power and increases gaps payable by the consumer.

Currently some health funds are including a 'no gap' clause in their day hospital contracts with respect to medical practitioners charges. Day hospitals do not employ their credentialed medical practitioners, and have no influence over the medical practitioner's account. This is a matter between the patient and the practitioner.

Due to 'gag' clauses in many health fund contractual agreements, it is difficult to provide specific examples. It would appear under these circumstances the day hospital has very little power in the negotiation process, the outcome of which subsequently impacts the consumer.

Concerns have been expressed regarding the application of the Private Health Insurance (Benefit Requirements) Rules 2011. This relates mainly to new services where Schedule Clause 8 is applicable and states *"an insurer has less than 5 negotiated agreements in force on 1st August for the first year with a particular category of comparable private hospitals in a State, then all of that insurer's negotiated agreements with all classes of private hospitals in that State are to be used to calculate the minimum benefit".*

Day Hospitals Australia is aware of at least two new services where Clause (8) should apply and in one case disclosure of Second Tier rates have been denied and in the other rates offered relate to the minimum default benefit, rather than the Second Tier Default Benefit.

This practice will stifle expansion of services available to the consumer. Often the service, for example Chemotherapy and Sleep studies would be more appropriately suited to the day hospital environment.

It is interesting to note that the 2016 PHIO data indicates that there were 1,312 more contractual agreements in the private inpatient hospitals than in the day hospital sector. In relation to this there were 282 private inpatient hospitals in 2014/15 and 342 day hospitals for the same period. There would appear to be some disparity here with respect to contractual agreements. Consumers are probably not aware that the four largest funds are in the bottom half of all open health funds by number of agreements.

Day Hospitals Australia is also very concerned by HPPA provisions, which we assert reduce competition in the marketplace. Specifically:

- Most HPPA's include provisions that require the day hospital operator to apply to the health fund for funding approval when commencing new specialities or even just increasing the volume of existing specialties. This actively discourages the day hospital operator from trying to win market share from competitor facilities including from more expensive overnight facilities. We note that possible reasons for increased volume of an existing specialty might be that the operator has attracted surgeons from a competitor facility, the health fund has acquired another health fund leading to a larger pool of members for that fund seeking admission to the facility, or a competitor facility has closed and so on. Clauses that effectively prevent the day hospital operator from growing his/her business reduce competitive behaviour and inhibit the migration of patient activity from more expensive to less expensive settings.

- All HPPA's include provisions pertaining to the possible assignment of the HPPA in the event of a change in beneficial ownership or control by either the health fund or the day hospital. But we especially note that some HPPA's require the day hospital operator to apply in writing for approval (from the health fund) to assign their interest in the HPPA whilst placing no such encumbrance on the health fund (i.e., the health fund does not need the written approval of the day hospital operator). Apart from being an asymmetrical arrangement (with greater power for one party than the other), we are anecdotally aware of a number of cases where the potential sale of a day hospital was hindered by these provisions in that the health fund sought to use its assignment 'veto' to renegotiate the terms and conditions of the HPPA. Thus the assignment obligations are not only asymmetrical, but they are being used inappropriately to leverage changes to other terms and conditions.

Many day hospital operators report that their HPPA's forbid them from accessing expert assistance from a consultant experienced in HPPA negotiations. However we understand there are no limits on the fund accessing consultants. Given the complexity of HPPA negotiations (which require advanced modelling, analytic and negotiation skills as well as a knowledge of casemix classification structures, regulations, industry minimum standards, outcome databases, etc.) this is most unreasonable and places the day hospital at a distinct disadvantage in a situation in which we believe there is already a power differential favouring the health fund. We consider these constraints only exist to optimise the outcome for the health fund by weakening the expertise of the day hospital. We propose that both parties should be able to use consultants as they see fit, observing of course the need for confidentiality. There should be no obligation on day hospitals to seek approval from the health fund before engaging expert assistance in this way.

Health insurers provision of information to consumers

Continual feedback from our membership indicates that misleading information is still being provided to consumers from their health insurance provider.

With reference to the current contracting behaviour of the four largest funds, consumers purchasing private health insurance products from these funds should be advised of the restricted choice that they have in regard to contracted hospitals. This information does not appear to be easily assessed, if at all. This information should be easily available consumers when considering a health insurer and their products as to where the cover can be used without incurring a gap payment.

Day Hospitals Australia continues to receive reports that some of the major health funds are advising their members to go to another hospital rather than attend where their doctor has organised their admission, telling the member that the particular hospital does not have a contract so that they will not covered for their scheduled treatment at that hospital. Insurance health fund staff have suggested that the patient go back to their doctor to be referred to another hospital where there is a contract in place. The patient is referred to the hospital by their doctor, and not the health fund. Sometimes the hospital may be the only facility where their doctor provides the specific treatment that the patient requires. This type of advice from health insurance fund staff adds significant stress, is inappropriate and misleading. In many cases, the hospital concerned would have a Second Tier Default arrangement in place. This behaviour from the health fund is impacting consumer choice. The privately insured consumer expects to have coverage for their care in a licenced and accredited private overnight or day hospital. The Second Tier Default Benefit acts as a safety net to ensure that the patient receives cover for the majority of their hospital account.

The consumer's understanding of their health insurance policy continues to be an issue, particularly with respect to exclusions and more commonly restrictions. There is confusion for example between what is considered plastic/reconstructive surgery and cosmetic surgery. The hospital then is often put in the position of clarifying the consumer's health insurance policy conditions, particularly in relation to co-payments and excesses on their policy. Many consumers misunderstand these payments as a hospital charge, and not a condition of their own health insurance policy, which by its inclusion has lowered their annual premium. Health insurance funds need to be much more transparent about these payments and when they are payable in any given year, providing the consumer with clear concise information on the conditions of their policy.

Private Healthcare Australia recently stated in their 1 March 2017 Press Release "*Recent IPSOS research shows that 84% of health fund members value their PHI because it gives them security and confidence they can access medical treatment when and where they need it".*

Same day treatment is the future of elective surgery and an increasing number of medical treatments. The day hospital sector provides a safe, quality, low risk, cost effective option for consumers who should not be disadvantaged by the practices of private health insurance funds.

Should you wish to discuss any of the above in more detail please do not hesitate to contact me directly on 08 9332 3606 or jane.griffiths@dayhospitalsaustralia.net.au

Yours sincerely

Jane Griffiths
Chief Executive Officer

ACCC (DHA Submission - Report to Senate on PHI) DRAFT 09.03.17.docx (JG/djp)