Australian Government

Private Health Insurance Ombudsman

Mr Bruce Cooper
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Dear Bruce

I refer to your letter of 3rd September 2012 inviting PHIO to comment on preliminary issues identified by ACCC in preparing its report to the Australian Senate on private health insurance (the PHI report).

In your letter you have outlined a number of areas you intend to focus on in this year's report and I have addressed these in my response.

Please contact me on (02) 8235 8709 or by e-mail at sgavel@phio.org.au if you would like further information or additional clarification regarding my comments.

Yours sincerely

Samantha Gavel

Samantha Gavel
Private Health Insurance Ombudsman
Friday, 14 September 2012

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PHIO Comments on Preliminary Issues Identified by the ACCC for its Report to the Australian Senate

Recognition of Allied Health Care Providers

Health insurers have considerable discretion to put together General Treatment policies that will appeal to consumers in their various target markets. The majority of General Treatment policies cover the most widely used services and treatments, such as dental and eye care services, physiotherapy, chiropractic and podiatry services.

Under General Treatment policies, insurers will only pay benefits for services provided by "recognised providers". These are providers that meet certain guidelines for the payment of benefits. Usually, these include requirements that the healthcare provider belongs to a professional association and is in private practice. For example, Medibank Private provides information on its website for providers about its requirements at the following link:

http://www.medibank.com.au/Health-Covers/Information-For-Health-Care-Providers.aspx

In addition, some insurers have "preferred provider" schemes, which pay higher benefits for visits to providers that the insurer has an agreement with.

Under Division 81 of the *Private Health Insurance Act 2007*, an insurance policy must meet certain quality assurance requirements. Benefits cannot be paid unless the treatment meets the requirements of the Private Health Insurance Accreditation Rules. It is therefore a legislative requirement that insurers ensure that providers they pay benefits for meet quality assurance requirements. This is designed to protect consumers by ensuring there are quality standards in place for providers whose services attract private health insurance benefits.

In cases where providers are not recognised by the insurer, the member must pay the full cost of the service themselves. PHIO received 17 complaints about non-recognised providers in 2011-12. These complaints related to a variety of services and providers that were not recognised by an insurer for benefits, including Remedial Massage, Acupuncture, Optical (specifically, an online contact lens provider), an Air patient transport service (i.e. privately operated air ambulance) Clinical psychology provided by Skype rather than face-to-face, Naturopathy and Chiropractic.

The ACCC's letter makes specific reference to providers of preventative and operative dental procedures. PHIO understands that some, but not all, insurers pay benefits for these providers. In reviewing PHIO's complaints data, it appears PHIO did not receive any complaints about this issue in 2011-12.

Podiatric Surgery

Podiatric Surgeons are currently required to be accredited by the Commonwealth Government in order to be eligible for private health insurance benefits.

When foot and ankle surgery is performed by an Accredited Podiatrist, insurers are required to pay the minimum default benefit towards the hospital costs. The default benefit covers the accommodation cost of being treated as a private patient in a public hospital in a shared room, but only covers a portion of the accommodation cost and none of the theatre fee in a private hospital.

Insurers must also cover the cost of a prosthesis that is associated with the surgery and is listed on the Government approved Prostheses list.

As there is no Medicare item number for a Podiatric Surgeon's services or the associated anaesthetist's service, Medicare will not provide a benefit towards these fees. This means it is not mandatory for a health insurer to pay benefits from their hospital tables for these medical costs. Health insurers may, however, consider paying benefits for such medical costs from their hospital treatment policies, but this is at their discretion.

If a Podiatric Surgeon is not accredited by the Commonwealth Government for the purpose of paying private health insurance benefits, then the health insurer will only be able to pay a benefit under its General Treatment (extras) policies and no hospital benefits will apply.

PHIO received 22 complaints relating to Podiatric Surgery in 2011-12. The majority of complaints were about the level of benefits received. Even if the Podiatric Surgeon is an Accredited Podiatrist, the member usually receives only a default amount towards the hospital accommodation – the remainder of the hospital fee, including the theatre fee, associated medical fees such as anaesthetist, and all or most of the Podiatric Surgeon's fee is the member's own expense.

Contracting Issues

Because contract disputes can have a significant detrimental impact on consumers' entitlements under their health insurance, PHIO has legislative power to mediate a dispute between a health insurer and a hospital, to assist in resolving the issues in dispute.

PHIO's role in contract disputes is intended to protect consumers, who may be adversely affected if their insurer no longer has a contract with a hospital they wish to attend. The aim of such mediation is to assist the parties to reach a position where direct negotiation between them is likely to resolve the matter. It does not involve PHIO ruling on the relative merits of the parties' negotiating positions or the prices they are seeking to pay or receive, which are commercial issues and therefore outside of PHIO's role.

During 2012, there were a small number of disputes between health insurers and healthcare providers in relation to the re-negotiation of their contractual agreements. PHIO provided informal advice to a number of parties in relation to these disputes and organised for independent mediation of two disputes. Following mediation, the parties to both disputes agreed to re-new their contractual arrangements.

A number of private hospitals in South Australia wrote to the ACCC and PHIO in August 2012 to express concern about rates paid to South Australian private hospitals by health insurers.

PHIO has advised these hospitals that as their concerns relate to competition and commercial issues, these are most appropriately dealt with by the ACCC. PHIO has forwarded one of the complaints to the ACCC and the CEO of another hospital group has written to the ACCC directly. I understand the ACCC is currently reviewing these complaints.

Complaints about Policy Restrictions and Exclusions
PHIO received 215 complaints about policy exclusions and restrictions in 2011-12, making this the second most complained about sub-issue for the year. There has been a continuing increase in complaints about this issue in recent years, which reflects the higher number of policies available for sale that have restrictions and exclusions.[1]

Complaints about restrictions and exclusions usually occur when a member requires hospital treatment and finds out before or on admission to hospital that the service is not fully covered under their policy.

Analysis of complaints to PHIO about this issue reveals three main factors contributing to these complaints:

a) *Insurer terminology:* Insurers need to explain exactly what a restriction or exclusion means in non-medical terms: terms such as 'plastic and reconstructive', 'obesity related surgery' and even more well-known ones such as 'cardio-thoracic' and "major eye surgery" are not fully understood by most consumers.

b) *Policy Complexity:* Some restricted policies are unnecessarily complex, or structured in ways that don't conform to the way hospital care is provided. For example:

   - Policies that cover investigative/diagnostic surgery, but not the subsequent treating surgery;
   - Policies that cover treatments such as appendicitis that can present with similar symptoms to treatments that are not covered under the policy;
   - Policies that cover day-only surgeries, but not overnight stays;
   - Policies that cover treatment in cases of accidents and/or emergencies only, but don't clearly define accident or emergency.

   These policies make it difficult for members, hospitals and even insurer staff to determine what is and isn't covered under the policy.

c) *Policy Downgrades:* Removing benefits from existing policies causes long-term problems. Even if full information about the change has been supplied by letter and follow-up information campaigns, members often don't realise the new

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[1] See the "Operations of the Private Health insurers Annual Report 2010-11", p19, PHIAC

restriction exists until they need the service. It is not unusual for PHIO to receive complaints from members about removal of benefits for certain treatments that occurred some years previously. In 2011-12, fewer insurers imposed new restrictions or exclusions on existing polices, so there was a decline in complaints about this issue to the office.

Waivers of Waiting Periods

Insurers frequently conduct marketing campaigns which advertise a waiver of waiting periods. In the majority of cases, however, the only waiting period that is waived is the two month waiting period for General Treatment cover.

PHIO receives regular complaints from members who have joined during a waiver of waiting periods and incorrectly assumed that all of their waiting periods were waived. It is important that insurer staff explain which waiting periods are waived and which are not during such campaigns and that the new member is also given a written letter or document that also explains this information.

In cases where this has not occurred and the member has incurred out-of-pocket costs due to the imposition of a waiting period which they thought had been waived, PHIO will recommend that the insurer pays these costs.

Hospital Co-payments

In 2011-12, PHIO received 30 complaints[2] about the imposition of a compulsory fee to access television and internet Wi-Fi services, which was introduced by a large hospital provider.

The fee was initially introduced for day-stay and overnight patients ($15 and $25 respectively), but the fee for day stay patients was removed in October 2011. The fee for overnight patients, however, remains in place.

Fees for the use of incidental services such as television access can be charged by hospitals, but usually only where the member wishes to use the service and agrees to the charge. In this case, however, the hospital provider imposed the fee on a compulsory basis, regardless of whether the patient wished to, or could use the services.

Patients who complained to PHIO about the fee included people with a disability who could not use the services and people requiring multiple admissions, who could not afford to pay the fee more than once.

The hospital provider's view was that providing Foxtel and Wi-Fi services in its hospitals required a significant financial investment, which needed to be recouped via a compulsory charge on patients, as health funds do not usually pay for such services.

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[2] PHIO received 29 complaints about the fee in 2010-11.

PHIO's view remains that such fees should only be charged to those patients who wish to use the services. PHIO has taken up its concerns about the fee with the hospital provider and the Australian Competition and Consumer Commission (ACCC).

The ACCC has advised PHIO that it does not believe the fee constitutes a breach of the *Competition and Consumer Act 2010*. The ACCC did indicate, however, that it had requested the healthcare provider to advise all medical practitioners working in its hospitals about the fee, so that they could inform patients about it in advance of booking into hospital. The ACCC also requested the healthcare provider to provide guidelines to its hospitals on the use of the discretion to waive the fee in circumstances where, for example, the patient has a disability and cannot use the services.

It appears that these requirements have assisted in reducing complaints from patients about the fee, as PHIO has not received any complaints about the fee in recent months. PHIO remains concerned, however, about the imposition of this type of compulsory fee on patients by hospitals and the potential for the practice to become more widespread.