Australian Society of Ophthalmologists

Mr. David Salisbury
Acting General Manager
Consumer & Small Business Strategies Branch
Australian Competition & Consumer Commission
Via email: phireport@accc.gov.au

Dear Mr. Salisbury,

Re: ASO Submission to the ACCC report to the Senate on private health insurance industry.

Thank you for the opportunity to submit comment on the activities of health funds operating within the Australian private health insurance industry.

The Australian Society of Ophthalmologists Ltd (ASO) is Australia's peak medico-political body representing ophthalmologists and their patients. A key function of the ASO is to promote access to high quality eye care for all Australians. Membership of the organisation is made up of ophthalmologists, trainee ophthalmologists and ophthalmic practice staff in all states and territories across Australia.

In developing this submission to the ACCC the ASO undertook a survey of our members. The survey, conducted last month, sought to gather feedback on ophthalmology practices' experiences negotiating contracts and lodging claims with health funds on behalf of their patients. In addition the survey sought feedback on the experiences shared with ophthalmologists by their patients regarding making health fund policy claims. Ophthalmologists and their practice staff communicate directly with patients in relation to health fund policies on a daily basis. They are required to provide patients with informed financial consent of associated costs of their treatment and regularly called upon to assist patients in interpreting and applying their health fund cover for treatment options.

More than 20 per cent of ASO members participated in the recent survey. A number of the comments provided in the survey responses have been included in this submission (these comments are sign-posted).

In addition to using the results of the survey to inform our submission the ASO has drawn on information provided to the organisation during the past year by ophthalmologists and consumers (patients) who have contacted the ASO to either enquire or complain about a particular private health insurance experience.

Utilising all information available the ASO has identified a number of issues and concerns regarding the activities of private health insurers, which we will detail below.

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1. PRACTICES BY PRIVATE HEALTH FUNDS REDUCING HEALTH COVER FOR POLICY HOLDERS AND INCREASING OUT-OF-POCKET EXPENSES

1.1. Preferred Provider and Preferred Hospital Schemes

Increasingly, we are seeing health funds using their market dominance to limit choices and control fee setting in the marketplace in a manner which is reminiscent 'in effect', of third line forcing.

An example is the Bupa "Member's First" network of preferred providers[1]. This scheme is negotiated between the health fund and hospitals (including day hospitals) in an attempt to coerce visiting doctors to perform 'no gap' surgeries that are remunerated below their normal fee.
The hospital is offered a beneficial theatre fee by the health fund if it insists that the visiting doctor only charge a 'no gap' fee. If the doctor refuses, then the hospital refuses to provide the doctor with access to its theatres. This has the effect of limiting or removing the doctor's choice of hospital and likewise limits a patient's choice of surgeon and hospital. The patient usually ends up with far greater costs as a result of these limitations placed on doctor and hospital if they do not comply because the health fund effectively refuses to provide health insurance and the patient has to be processed as a non-insured patient.

In effect the health fund is using the hospital to force the doctor (and patient) into an altered fee arrangement to the benefit of the conspiring parties. Where the hospital refuses to act as an agent of coercion, it has its contract removed at the next renewal.

In small community regions where there are limited choices of hospital it forces the doctors and day hospitals to 'toe the line' or have no place to perform the surgery and no coverage for the health fund member, who has chosen their surgeon. In larger metropolitan settings it is used to threaten smaller day surgeries and force them to coerce doctors into the 'no gap' fee (on behalf of the fund) with the threat of not having the health fund contract not renewed and handed to a neighbouring hospital.

It is telling that fund members are not provided with any information about these contractual arrangements, other than to be told that a doctor or a hospital is 'not preferred' and may not be covered by their insurance. Many doctors would actually choose to charge the 'no gap' fee (or a low compassionate fee) in any case – but most doctors refuse to be contractually bound because it is seen as a slippery slope towards handing health funds complete control of commercial arrangements. Where the doctors refuse the contract, it is often the patient who misses out on access to private healthcare and thus incurs increased unexpected expense.

[1] Bupa, Bupa Hospital Arrangements, accessed 28 April: https://www.bupa.com.au/health-insurance/member-health-benefits/bupa-hospital-and-medical-arrangements

In the private health industry, all negotiations between the health funds and hospitals are contractually confidential. This eliminates the possibility of hospitals 'comparing notes'. The health funds however have full knowledge of all the contractual arrangements. This asymmetry of knowledge allows the health funds to manipulate day hospitals is regions to maximise their profits and use the hospitals to force doctors to accept contracts which they feel to be non-commercial.

The ASO seeks clarification and a ruling on these types of arrangements.

> **Survey comment: "**Patients have no idea that the different funds pay different rates for surgery at our day surgery, resulting in some being charged a gap and others not. This comes as an enormous surprise to them."
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> **Survey comment:** "I currently work at a new hospital which is a more convenient location for my patients but many major funds (Medibank Private, AHM, NIB, HCF, NIB) are refusing to enter into a contract with the hospital which means my patients have to pay an additional hospital facility fee, in addition to any excess/co-payment that the individual funds may apply. In other words these funds are forcing me and my patients to go to their preferred hospitals. Thus a form of managed care."
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> **Survey comment:** "Some health funds give a larger rebate if their own provider is used. For example, spectacle dispensing rebate or dental treatment. This seems to be to be anti-competitive, and I feel an insurance provider should not have any financial interest in particular provider of these services, for example BUPA optical."

1.2. Pre-approvals

In the past 12 months major insurers such as Medibank Private, Bupa and AHM have begun demanding doctors, including ophthalmologists, sign pre-approval forms for Medicare Benefits Schedule listed surgeries before they will agree to uphold a member's cover.

It is the view of the ASO that these signed pre-approvals (Specialist Eligibility Forms) directly interfere with the doctor patient relationship and are negatively impacting on patient care. They also appear to contravene the Private Health Insurance Act 2007.

In the case of ophthalmology signed pre-approvals are now regularly sought for the following MBS item numbers: 45617, 45623, 45624 and 42590.

As a result of pre-approval processes patients have been forced to cancel procedures due to lack of certainty around their health fund cover. In other cases patients have incurred unanticipated out-of-pocket expenses.

The Minister for Health the Hon. Sussan Ley has confirmed with the ASO that there is no requirement under the Private Health Insurance Act 2007 (the Act) for any private health insurance consumer or any relevant authorised medical practitioner to complete or otherwise engage in any type of pre-approval process with any private health insurer.

Minister Ley advised the Act provides that if a member of a fund is insured for a certain treatment under a Complying Health Insurance Product (CHIP) and receives hospital treatment that includes a procedure for which a Medicare benefit is payable and is paid for that treatment, then the private health insurer must pay the benefit linked to that procedure.

Minister Ley further advised that the Department of Health officers had met with several of the major health insurers and written to all insurers to outline the Government's position on this matter.

Despite this communication from the Minister all funds (Bupa, Medibank and AHM) have continued to issue requirement for signed pre-approvals.

1.3. Suggested strategy for improvement

Diversity of healthcare providers in Australia results in a competitive market with healthy competition. However, negotiating tactics of health insurers will lead to increased corporatisation of Australian healthcare as seen in overseas markets such as the United States.

Intervention is now needed to restrict the ability of health funds to coerce healthcare practitioners to use facilities controlled by health funds and also restrict practitioner choice around 'gap cover' rebates for patients. Healthcare treatment options for patients should not be controlled by restrictive health funds that are operating in the interest of shareholder profits as opposed to outcomes for their customers.

2. DIFFICULTY INTERPRETING & APPLYING HEALTH FUND POLICIES INCLUDING EXCLUSIONS AND RESTRICTIONS, INCLUDING POLICY CHANGES

2.1. General policy interpretation

The results of our survey, coupled with regular consumer-initiated contact with the ASO over ophthalmology-related private health insurance policy confusion, delivers a strong message that health fund policies are not well understood by consumers.

More than 98 per cent of ophthalmologists we surveyed said their patients did not receive sufficiently clear information from health funds in order to make appropriate decisions regarding health insurance products.

Further to this, doctors highlighted that consumers from non-English speaking backgrounds, elderly patients, those with poor vision or reduced cognitive awareness incur increased difficulty reading and understanding health fund communication such as their policy statement.

> **Survey comment:** "Health funds do not have plain English information brochures to explain the exclusions of each type policy nor are the insurance funds staff capable of sitting down with each patient to explain best policy for their current needs. They usually promote their cheapest policy to get clients signed up rather than what the patient actually needs."

2.2. Exclusions and restrictions

The ASO has identified a troublesome lack of clarity around the exclusions and restrictions that health insurance funds place on many of their products.

In responding to our survey 86 per cent of doctors said their patients do not adequately understand exclusions and restrictions relating to the private health policies they pay for.

In terms of ophthalmic surgeries covered by private health insurance policies, almost 50 per cent of doctors who participated in the survey said their patients 'rarely' or 'never' understand which ophthalmic surgeries are covered under their health fund's definition of 'major eye surgery'.

The practical implications of 'unknown' exclusions and restrictions are of course extremely broad and therefore difficult to detail. However, a selection of doctor comments from our survey which is provided below does serve to highlight a few examples.

Survey comment: "Patients are often unaware of exclusions and excesses, or what "basic" cover or "public hospital cover" means."

Survey comment: "I am seeing many more patients who think they are covered for cataract surgery but who in fact have had their policies downgraded so that it is excluded."

Survey comment: "Health fund advertisements target promoting health and fringe benefits for younger age groups but don't clarify hospital cover and there are a lot of exclusions."

Survey comment: "Young patients who choose a policy with limitations understand that they are not covered for elective surgery, for example cataracts. However, when young people suffer a retinal detachment and need emergency surgery for a blinding condition, they are shocked to find out they are not covered. An acute blinding condition like retinal detachment is a perfect example of the exact sort of condition they wanted to have cover for if the need arises. For something that is statistically rare, 1 in 100 000, there is no need for it to be excluded from policies in the first place."

Survey comment: "An example is Botulinum Toxin (MBS item 18366) used for strabismus surgery (commonly occurring in children) under general anaesthetic is not covered by health fund policies. This results in a significant number of patients who do not receive access to viable treatment for acute strabismus."

2.3. Policy changes

Doctors surveyed also identified that in some cases a policy change or exclusion regarding one surgery can result in the cancelling out of other surgeries and leave consumers (patients) feeling blindsided.

The situation could be termed a 'multiple procedure scenario'. In a scenario such as this funds such as HCF and Bupa have shown they will not provide any cover at all if any one of the procedures being performed is not included within a policy.

A real life example is as follows: In March the ASO received a complaint from a Bupa member who had received treatment to both eyes for blepharoplasty. One eye was functional as the lid interfered with the patient's vision, yet the other eye had not yet deteriorated to the same level and therefore did not meet a functional MBS definition. The ophthalmologist operated on both eyes in a single hospital admission to save on duplication of resources and reduce the patient's time in hospital. Bupa, however, refused to cover either surgery despite the fact the patient's health policy covered them for one of the surgeries.

2.4. Suggested strategy for improvement

Private health insurance policies need to effectively communicate exclusions and restrictions to ensure that consumers are fully informed about the limitations of their policy prior to making the decision to purchase it.

One strategy to achieve this could be the provision of case study scenarios highlighting instances where exclusions and restrictions have 'unexpectedly' impacted on policy holders.

Other strategies health funds could employ towards providing better communication include:

- Using plain English in all written communication
- Providing policy documents with large easy to read print
- Policy holders should be asked to register their agreement (by signature) to accept any changes to their policy when these changes are introduced.
- Providing improved access to phone consultations with health fund staff to offer explanations of policy changes.

3. CONSUMERS BEING SOLD INAPPROPRIATE PRIVATE HEALTH INSURANCE POLICIES

More and more ophthalmologists are reporting to the ASO that inadequate advice provided from health funds selling insurance products is seeing their patients purchase policies, which are not risk-appropriate.

It is almost impossible for a person to accurately predict their individual likelihood of developing disease or experiencing injury, and as health funds continue to abandon community rating in favour of 'complex scale' of health cover options, consumers will be increasingly exposed to high-risk health insurance coverage.

One area where this move towards high-risk heath insurance coverage is clearly leaving patients exposed is eye disease.

We know that diseases such cataract, glaucoma, and macular degeneration all occur in much higher rates in older population demographics. Age-related Macular Degeneration affects one in seven people over the age of 50. One in 10 people over the age of 80 has glaucoma. Association with aging means all people will develop cataract to some degree by the age of 80[2]. Any of these diseases left untreated will result in vision impairment or compete vision loss.

[2] Centre for Eye Research Australia, Your eye health, accessed 28 April 2016 http://www.cera.org.au/community/your-eye-health/

Despite these known risks, health insurance funds appear to be increasingly amending a majority of policies to exclude eye surgery or other ophthalmic treatment.

As noted above, close to 50 per cent of doctors who participated in the ASO survey said their patients 'rarely' or 'never' understand which ophthalmic surgeries are covered under their health fund's definition of 'major eye surgery'.

> **Survey comment:** "The near universal exclusion of major eye surgery from a majority of my patient's policies is clinically unjustifiable and societally irresponsible."
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> **Survey comment:** "Patients over 50 should be warned to think very carefully about buying a policy that excludes major eye, joint replacement and cardiac surgery."

Other obvious eye health risks are also commonly not communicated to consumers when purchasing private health insurance products. For example, cataract can affect people of all ages as a result of unprotected sun exposure or trauma associated with other types of eye surgery. This makes the need for cataract and lens surgery a real possibility for younger age groups also.

> **Survey comment:** "A recent patient needing a Descemets Stripping Endothelial Keratoplasty (DSEK) corneal graft for Fuchs dystrophy was told a policy excluding cataract surgery was suitable for them. However cataract surgery often results due to trauma of this surgery leaving the patient not covered for the subsequent required cataract treatment".
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> **Survey comment:** "A lot of younger patients who have had eye surgery excluded on their policies are disappointed when their keratoconic graft is not covered."

Meantime, the ASO has identified issues with health insurance policies marketed as a tax-mitigation strategy. These policies often provide the lowest possible cover (in particular, public hospital-only policies which market private health benefits received within a public hospital).

For example AHM's 'Do you have a boring body?' marketing campaign[3]. Products relating to this marketing campaign are regularly targeted at younger, supposedly 'healthier' patients, in many cases patients who may not be able to afford other types of premium level cover. The ASO is concerned that these policies often have extreme level exclusions and that consumers are not adequately communicated with about the consequences of choosing this type of cover. For example, their admission to a public

[3] AHM, 'Got a boring body like Greg?', accessed 28 April 2016: https://ahm.com.au/

hospital may still be subject to lengthy 'public' waiting lists.

> **Survey comment:** "A 60 year-old patient being sold a "young singles policy" after he was widowed and the health fund said he was healthy and this was cheapest for him, unsurprisingly he was not covered for cataract surgery."

3.1. Suggested strategy for improvement

The variety in decision making surrounding one's risk profile is far too great for any person to decide. Levels of cover need to be streamlined with less variation.

Health funds should take more responsibility in communicating the increased health risks to patients as they age. Statistics of diseases for people over the age of 50 should be included in communication before policy decisions are made.

The ASO is happy to discuss further provisions of this submission with the ACCC if required.

Sincerely,

Dr Michael Steiner
President
Australian Society of Ophthalmologists

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