ISSUES PAPER: OUT-OF-POCKET COSTS

Introduction

In Australia, if a patient is admitted to a public hospital as a public patient, generally the patient is not charged for any hospital or medical services. If the patient chooses to be treated as a private patient, in a public or private hospital, each of the doctors and health professionals may charge a fee. These fees are in addition to the fees the hospital may charge for accommodation and other hospital services for private patients. The difference between the fee, and the combined Medicare and private health insurance benefits, is paid by the patient "out-of-pocket".

Out-of-pocket costs have been a long-standing concern for the private health industry. Consumers are often required to pay large and/or unexpected out-of-pocket costs, which contributes to a perception that private health insurance provides poor value for money.

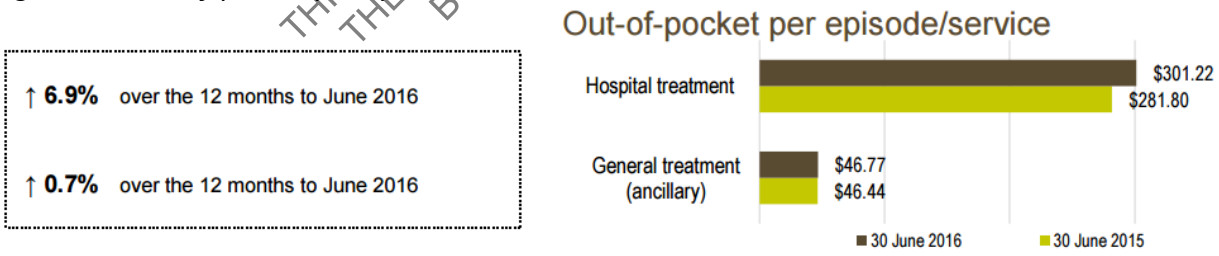
Please note that figures in this paper are drawn from multiple sources, and may not be directly comparable. Except for previously published data, figures in this paper should not be quoted, or used for any purpose other than informing the Private Health Ministerial Advisory Committee.

Background

In 2015, the department conducted a consumer survey on private health insurance. Over 40,000 responses were received. The survey found consumers were concerned about being left with large out-of-pocket costs and not knowing what those costs would be.

Consumers may face out-of-pocket costs for general treatment, hospital accommodation and admitted patient medical costs. According to APRA, the average out-of-pocket cost in the June 2016 quarter was $301.22 for hospital treatment (both hospital and medical charges), and $46.77 for general treatment (see figure 1)[1].

Figure 1 – Out-of-pocket per episode/service



Source: APRA Quarterly Statistics June 2016

General Treatment Out-of-Pocket Costs

General treatment cover provides benefits for treatment by ancillary health service providers. Nearly all services covered under general treatment have some kind of limit on benefits paid. There are various limits that may apply, for example a maximum amount or percentage limit per service, per year, or lifetime limits.

[1] Note that the definition for out-of-pocket in Figure 1 refers to the amount paid by a policy holder for a service after private health insurance benefits and Medicare benefits are paid. Out-of-pocket may include medical gap, excess or co-payments for hospital or hospital-substitute episodes, and co-payments for general treatment services.

Many insurers establish 'preferred provider' or 'participating provider' arrangements with some suppliers of general treatment services. Those providers offer an agreed charge for fund members, often resulting in lower or no out-of-pocket costs.

Some funds have also established their own service providers, such as dental and optical centres. These are usually only located in capital cities or major population centres. Consumers who use a fund's own dental or optical centre will normally face no or lower out-of-pocket costs.

Figure 2 shows that dental is overwhelmingly the general treatment service with both the highest benefits paid and out-of-pocket costs. This is followed by optical, physiotherapy and chiropractic.

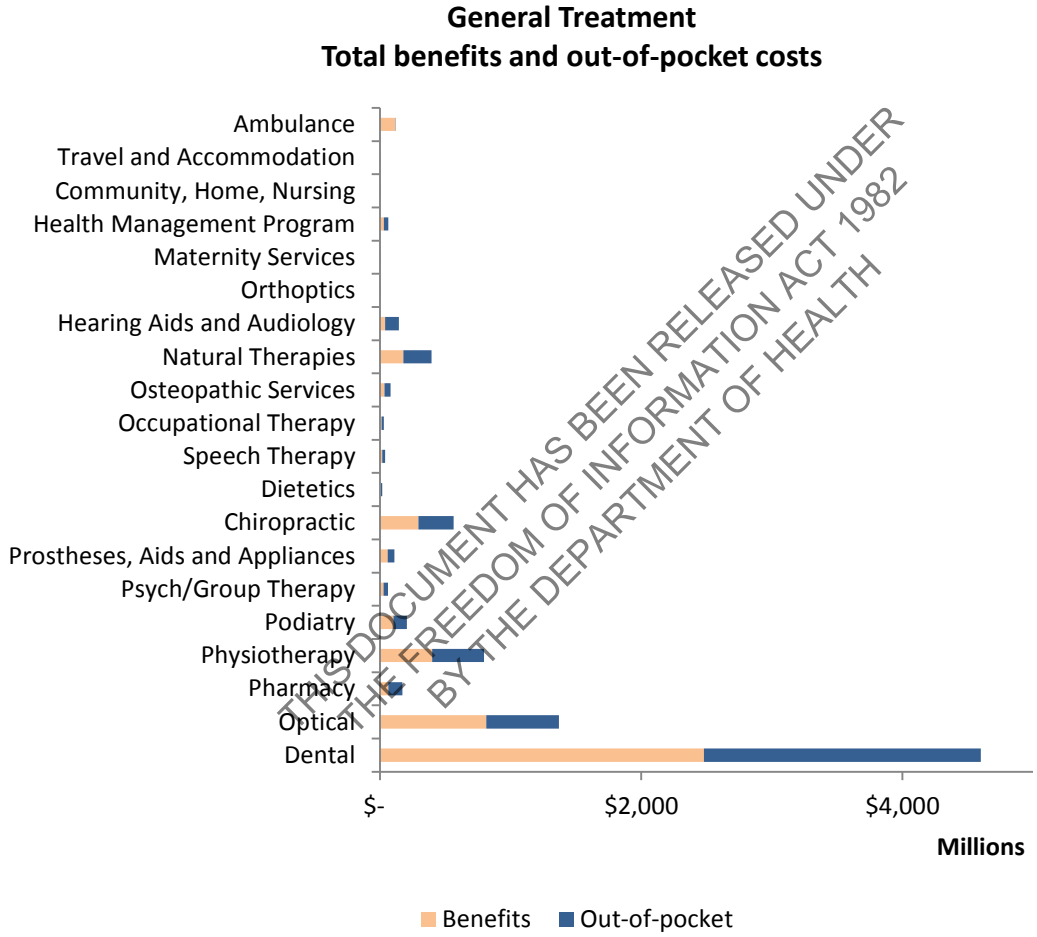


Figure 2 – General Treatment Benefits and Out-of-Pocket Costs 2015-16
Source: APRA Private Health Insurance Membership and Benefit Trends September 2016

Figure 3 shows benefits and out-of-pocket costs per service. The largest benefits paid per service are for ambulance, hearing aids and audiology, and prostheses, aids and appliances. The largest out-of-pocket costs per service are for hearing aids and audiology, prostheses, aids and appliances, and psychology.

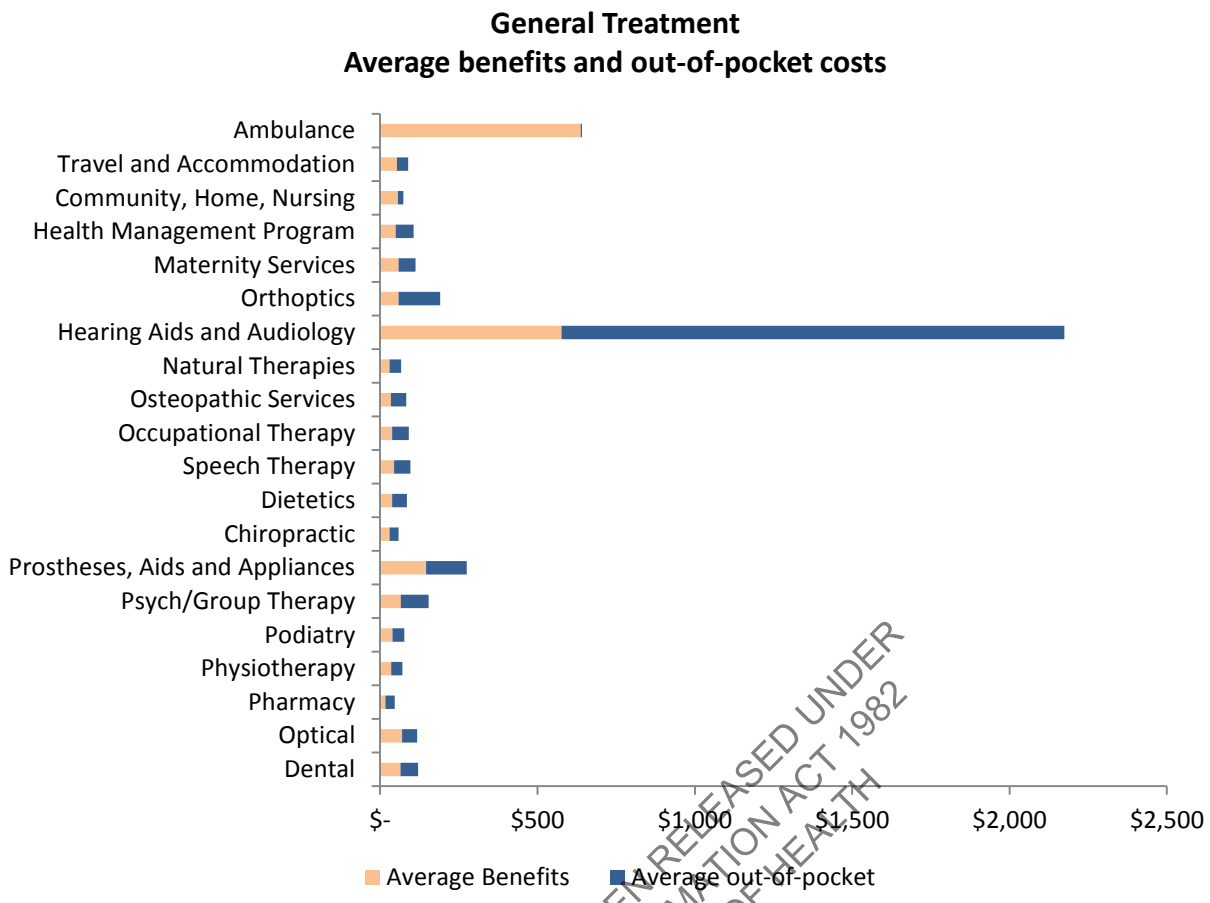


Figure 3 – Average General Treatment Benefits and Out-of-Pocket Costs 2015-16
Source: APRA Private Health Insurance Membership and Benefit Trends September 2016

Total dental out-of-pocket costs are high within the context of general treatment services. However, as shown in figure 3, average benefits and out-of-pocket costs are relatively low, and both benefits paid and out-of-pocket costs have been relatively stable in recent years (figure 4).

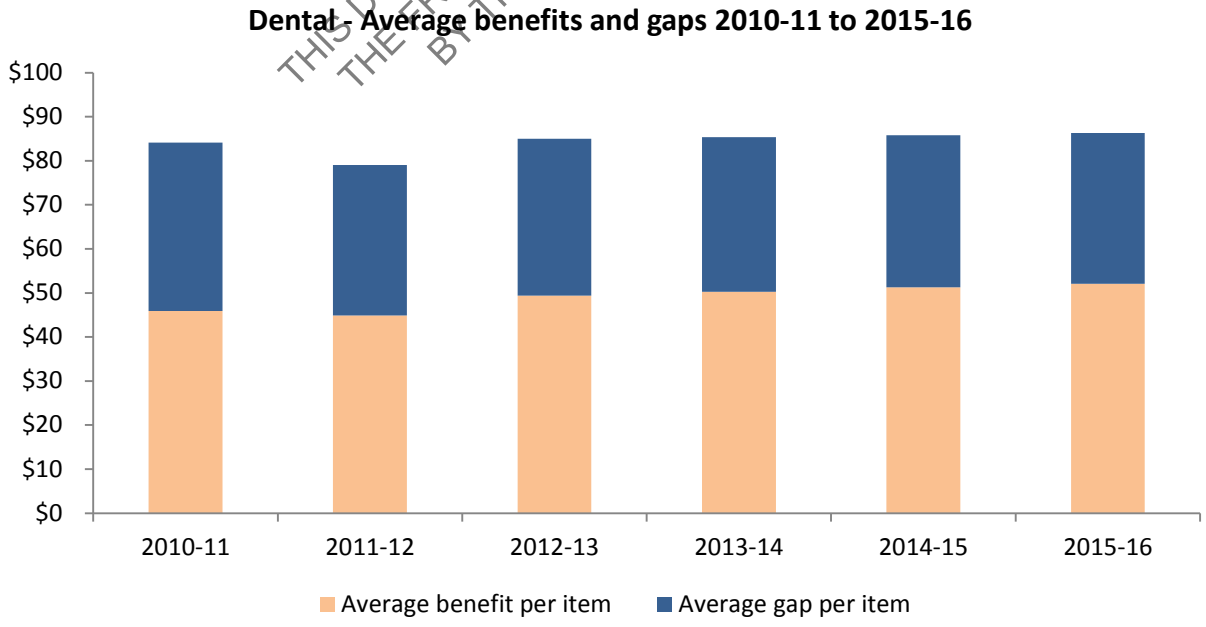


Figure 4 – Dental average benefits and gaps
Source: Department of Health General Treatment Dental Collection (21 most common item numbers)

As the Committee has previously observed, general treatment cover tends to functions more as a partial reimbursement scheme than as a traditional insurance product. Funding models for general treatment is on the Committee's workplan for 2017. Therefore, this paper will not consider general treatment further.

Hospital and Medical Out-of-Pocket costs

Hospital insurance provides benefits for both hospital and medical costs. Figure 5 shows the average out-of-pocket costs for hospital and admitted medical services per episode by hospital treatment category.

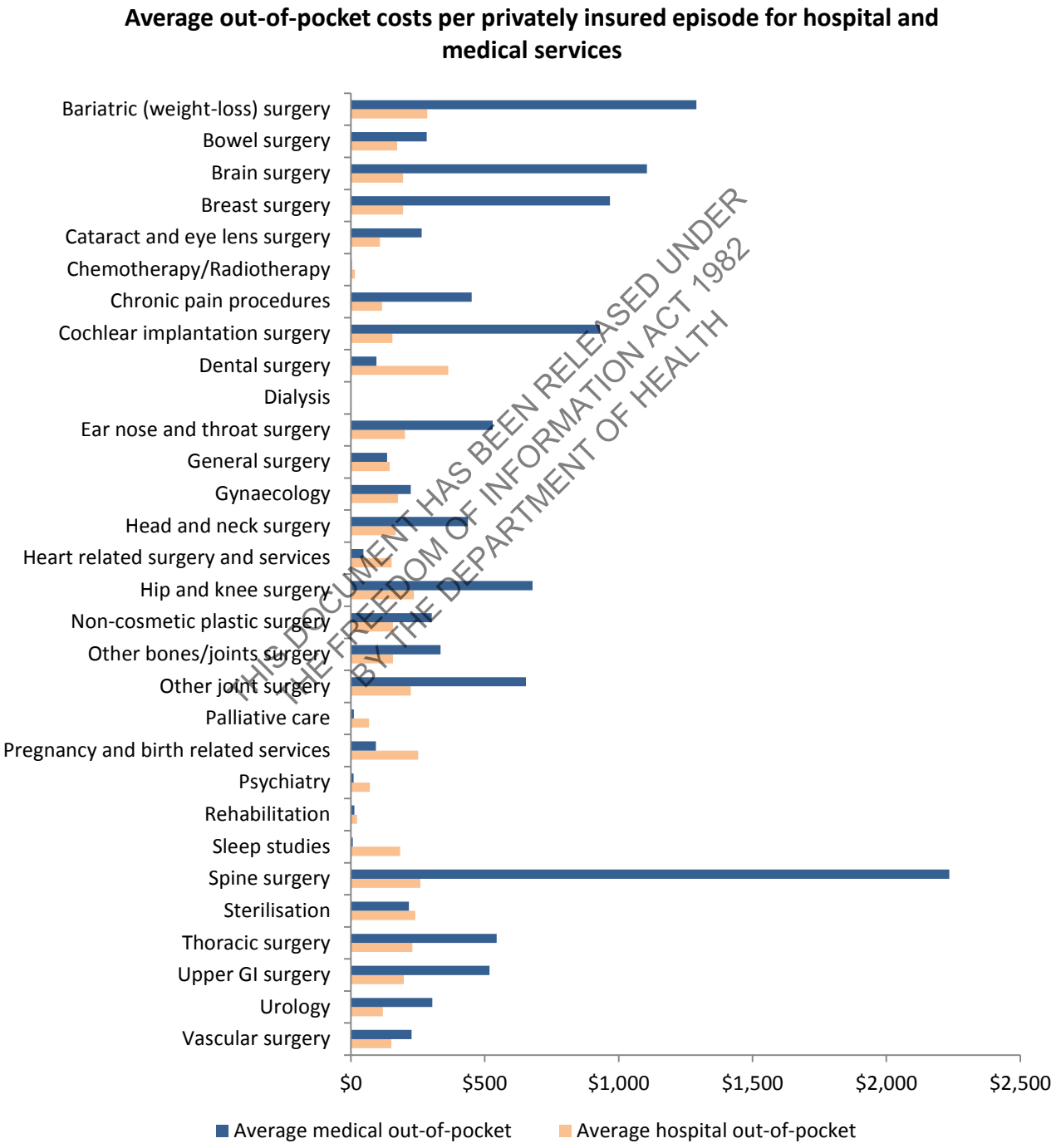


Figure 5 – Hospital treatment – average hospital and medical benefits and out-of-pocket costs by privately insured episode

Source: Department of Health Hospital Casemix Protocol 1 Data 2014-15

Figure 5 shows that hospital and medical out-of-pocket costs are significantly different, and that medical out-of-pockets are generally the higher. Given these differences, it is useful to look at hospital and medical out-of-pocket costs separately.

Hospital Out-of-Pocket Costs

Since the passage of amendments in 1995 to the *National Health Act 1953*, health funds have been able to negotiate Hospital Purchaser Provider Agreements ("contracts") with hospitals. Generally, when a contract is in place, the hospital agrees not to charge more than the contracted amount, so the insured person will not incur out-of-pocket hospital accommodation costs other than the costs specified in their health insurance policy such as an excess or co-payment, or incidental costs that may apply for extra services. Over 80% of all hospital policies include an excess. While excesses do form part of out-of-pocket costs, they are somewhat different to other out-of-pocket costs: these costs are voluntarily accepted by consumers in return for lower premiums, and consumers are aware of these costs at the time they purchase their insurance product.

Where there is no contract between a private hospital and an insurer, either minimum or second tier default benefits are paid. Where default benefits are paid, the insured person is likely to incur out-of-pocket costs reflecting the difference between the amount charged by the hospital and the benefit paid by the insurer.

Table 1 compares the charges, benefits and out-of-pocket costs for hospital costs (excluding medical) for private patients in day hospitals, private overnight hospitals and public hospitals. These costs are relatively small in both dollar terms and as a proportion of the hospital charge. The out-of-pocket costs in table 1 include excesses paid by patients, which indicates that the average unexpected out-of-pocket cost for hospital services is low.

Table 1 – Private patients in day hospitals, private overnight hospitals and public hospitals 2014-15

Hospital Type	Separations ('000)	Hospital Charges ($m)	Hospital Benefits ($m)	Out-of-Pocket* ($m)	Average Out-of-pocket	% Out-of-Pocket
Day Hospitals	674	$555	$480	$75	$111.58	14%
Private Overnight Hospitals	2,782	$9,289	$8,909	$380	$136.68	4%
Public Hospitals	813	$1,156	$1,055	$101	$124.13	9%
Total	4,270	$11,000	$10,444	$557	$130.33	5%

Source: Department of Health Admitted Patient Care and Hospital Casemix Protocol 1 Data 2014-15
*For this analysis, out-of-pocket = charges less benefits. Note that this may include excesses and other out-of-pocket costs and that in some cases (e.g. private patients in public hospitals) some costs may be waived.

Medical Out-of-Pocket Costs

The Commonwealth sets an MBS fee for clinical services. Medicare pays 75 per cent of the MBS fee for each MBS item provided as part of private admitted hospital treatment. The health insurer pays the additional 25 per cent (if the procedure is eligible under the health insurance policy). Where a no or known gap arrangement is in place, the insurer may pay an additional

benefit above the MBS fee. The difference between the fees charged by the doctor, and the combined MBS and private health insurance benefits, is the patient's out-of-pocket cost.

Figure 6 shows the average gap for private admitted medical services where a gap was paid and the percentage of services which have a gap. The average gap where a gap was paid in 2015-16 was $135.58. While this has decreased from $162.29 in 2014-15, the percentage of services which have an out-of-pocket cost has increased from 11.7 per cent to 14.6 per cent.

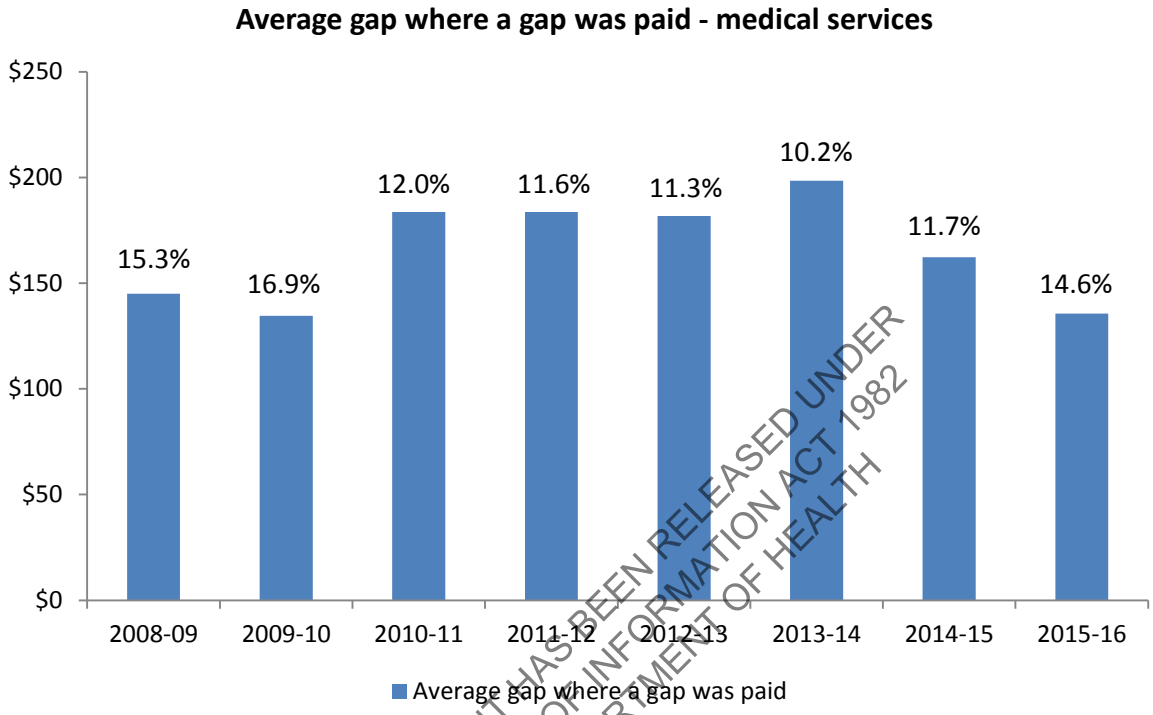


Figure 6 – Average gap where a gap was paid – medical services
Source: APRA annual report 2016, APRA Quarterly Statistics Medical Gap June 2016

An admitted hospital episode is likely to have more than one medical service, so the actual patient experience of out-of-pocket costs is likely to be higher than shown in Figure 6. Therefore, it's useful to look at out-of-pocket medical costs from both a macro and patient-level perspective. Figures 7 and 8 show total out-of-pocket costs (the cost to the system overall) and average out-of-pocket costs per episode (the costs to the individual patient) for medical services for private admitted patients.

Figure 7 shows the highest total out-of-pocket costs are for hip and knee surgery, urology, and ear nose and throat surgery.

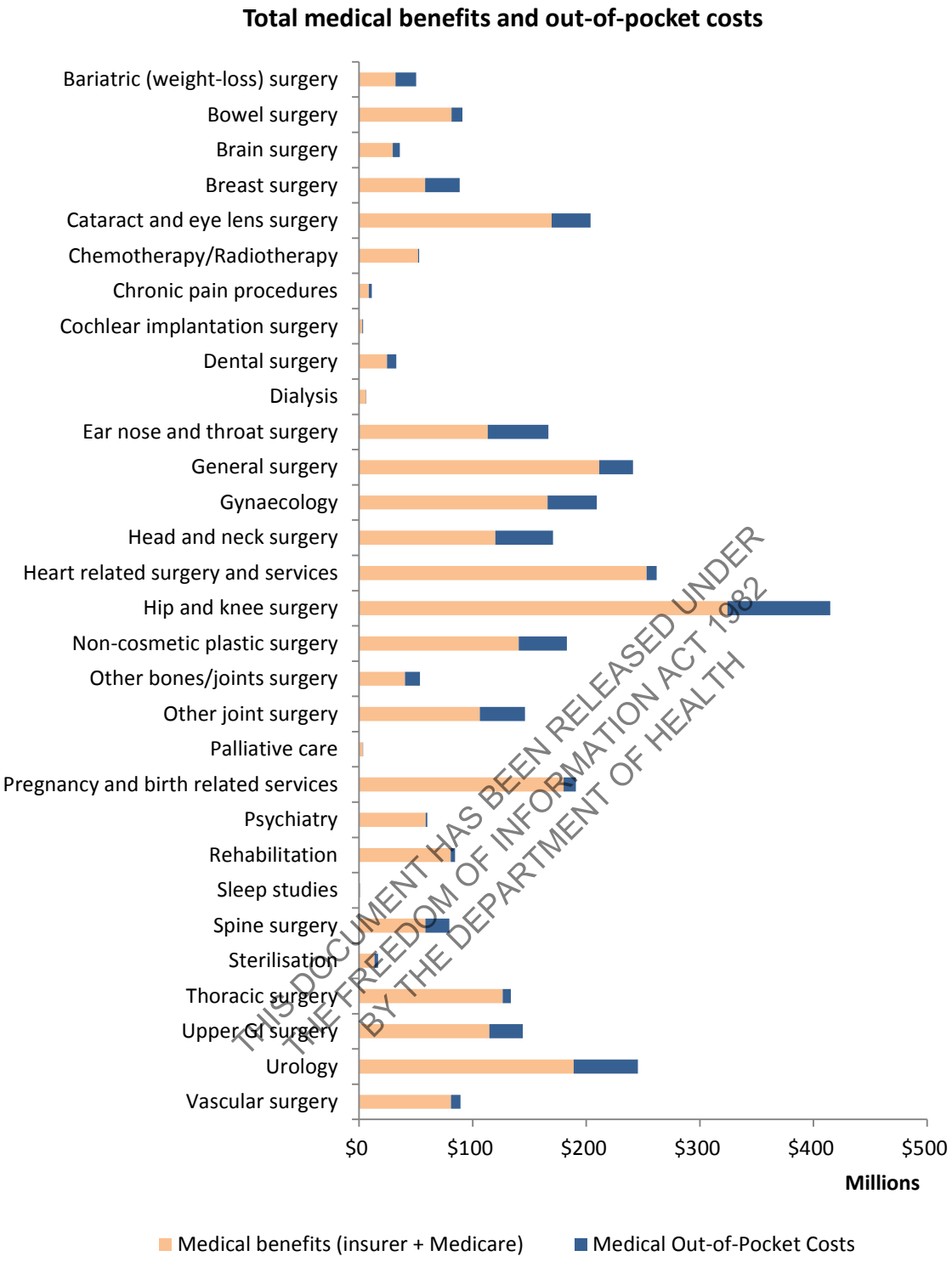


Figure 7 – Total medical benefits and out-of-pocket costs by episode type (excluding anaesthetics)
Source: Department of Health Hospital Casemix Protocol 1 Data 2014-15
Note: anaesthetic costs are not included as part of the related episode.

Figure 8 shows the largest average out-of-pocket costs per service are for spine surgery, bariatric surgery and brain surgery. Note that these episode-based figures tend to be significantly higher than the out-of-pocket cost per service shown in figure 6. This is because a single admitted hospital episode tends to consist of multiple services. The cost per episode is the better measure of the patient experience of out-of-pocket costs.

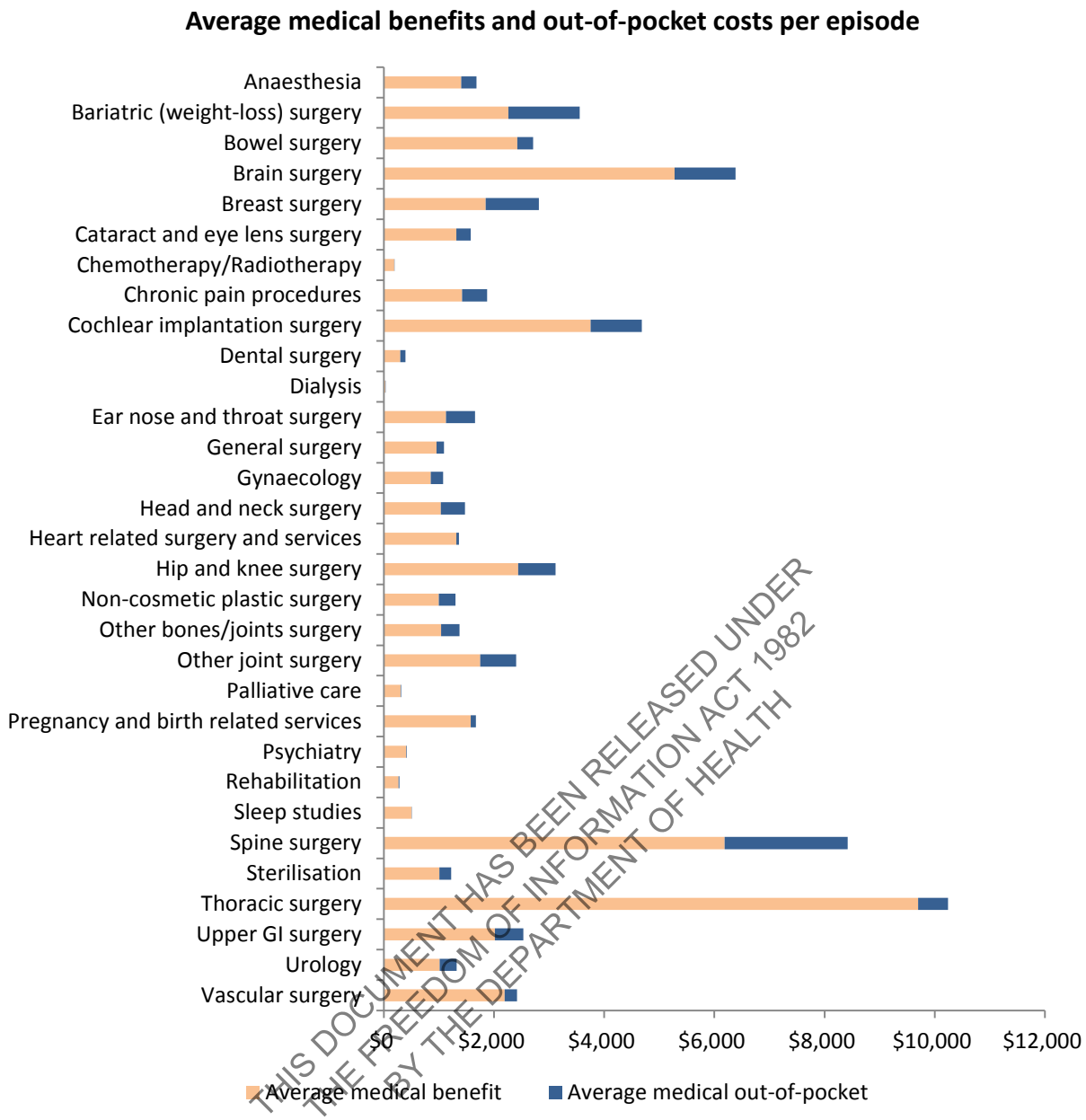


Figure 8 – Average medical benefits and out-of-pocket costs by episode type
Source: Department of Health Hospital Casemix Protocol 1 Data 2014-15.
Note: anaesthetic costs are reported separately, not as part of the related episode.

Discussion

Given the data presented above, the following discussion will focus on those out-of-pocket costs related to medical services.

Medical Gap Arrangements

Private health insurer medical gap arrangements are designed to eliminate or reduce the out-of-pocket costs incurred by the patient for admitted hospital medical services. If a service is provided under a 'no gap arrangement', it means the full medical charge is covered by Medicare and the health insurer, and the patient does not have any out-of-pocket costs. For a 'known gap arrangement', the insurer pays a specified benefit above the Schedule Fee, and the provider undertakes to charge no more than a specified gap.

Doctors are free to decide whether or not to use a particular fund's medical gap cover arrangements for each individual patient. Factors that can affect the use of the arrangement by doctors include:

- the level of fund benefits paid under the gap arrangements (compared with the doctor's desired fee); and
- the design of the fund's gap cover arrangements, including any administrative burden for the doctor.

In 2014-15, the proportion of services that were not covered through no gap or known gap arrangements nationally was 18 per cent. New South Wales had the highest percentage not covered with 25 per cent, followed closely by the Australian Capital Territory (22 per cent). Tasmania (8 per cent) and South Australia (9 per cent) have the lowest proportion of services not covered.

Fee setting

While there has been significant research on GP fee setting behaviour in Australia, there is limited research on specialist fee setting practice[2,3]. One study that directly addressed fee variation found that Australian specialist physicians practice price discrimination on the basis of their patients' income status. The study found there are significant differences in fees charged for the initial consultation between high and low income earning patients. Patient characteristics such as age, health concession card status and private health insurance status were used as proxies for income status. The study also found differences in fee charging behaviour based on where the practice was located, with practices in the highest socio-economic areas charging higher fees overall and also having the widest average fee gap[4]. While there is no directly comparable information for admitted patient services, it seems plausible that the situation would be similar.

Informed Financial Consent

Health consumers face the challenge of information asymmetry, where health professionals have access to more information than the consumer on many aspects of health care. This includes both clinical and fee information. This puts the doctor in both a powerful and privileged position over the patient. Despite recent progress in terms of both professional bodies' self-regulation and development of standards around informed financial consent (IFC), information asymmetry on price in the health system remains a significant factor in patient-specialist interactions.

IFC is the provision of cost information to patients, including notification of likely out-of-pocket costs, by all relevant service providers, preferably in writing, prior to admission to hospital or treatment. With full IFC, consumers should have information from their:

- doctor about whether or not they use their insurer's medical gap arrangement;
- insurer about excesses, co-payments or any other charges; and
- hospital about whether they have a contract with their insurer.

[2] Gravelle H, Scott A, Sivey P and Yong J (2013) 'Competition, Prices and Quality in the Market for Physician Consultations'. *Melbourne Institute Working Paper* No. 23/13.
[3] Richardson J, Peacock S, Mortimer, D (2006) '*Does an increase in the doctor supply reduce medical fees? An econometric analysis of medical fees across Australia'*. Applied Economics 38: 253-266.
[4] Johar M, et al (2016) '*Bleeding hearts, profiteers, or both: Specialist physician fees in an unregulated market'*. Health Economics. Feb 23. doi: 10.1002/hec.3317. [Epub ahead of print]

During 2007-08, the department worked with stakeholders to promote the use of IFC. The department worked with the AMA to increase the incidence of IFC obtained by medical specialists with limited patient contact. This resulted in an online IFC training package for anaesthetists, workshops for practice managers around Australia, and the establishment of an Australian Diagnostic Imaging Association IFC website.

Some private health insurers have mandatory IFC requirements for providers who participate in gap cover arrangements to protect their members from unexpected out-of-pocket costs. It is ultimately up to consumers to clarify what out-of-pocket costs they may incur. However, many patients find it difficult to ask about fees, and a lack of transparency means patients do not generally have information to assess whether the fee is reasonable.

Consumer Protection Law

The Australian Competition and Consumer Commission has a role in ensuring that professional associations provide maximum benefits to members, the broader business community and consumers by administering the *Competition and Consumer Act 2010*. Unconscionable conduct, although difficult to define, is generally regarded as conduct that is against what is right or reasonable. These factors include:

- the relative bargaining strengths of the parties;
- whether the stronger party required the weaker party to comply with unreasonable terms;
- whether the weaker party was able to understand relevant documents;
- whether the requirements of an industry code or voluntary code were met; and
- the extent to which the parties were willing to negotiate.

The department is not aware of any case where consumer protection law has been applied in relation to out-of-pocket costs for medical services.

Workforce Issues

The discussion of out-of-pocket costs is inextricably linked to doctor incomes. Any changes to out-of-pocket costs through changes to fees would impact on doctor incomes. Such changes would not only impact on the incomes of individual doctors, but could have larger workforce implications such as overall doctor supply or supply in particular specialties. This would need to be considered in the implementation of any changes, but might be managed through mechanisms such as staggered implementation of changes or controlled slowing in growth rates rather than absolute reductions.

Case Study - Obstetrics

- In 2014-15, the average out-of-pocket cost for admitted private patient pregnancy and birth related services was $344 ($251 hospital, $93 medical). These costs are relatively low compared with other treatment types shown in figure 2. However, they do not include the so-called “booking fee”, which is common for obstetric services and is not covered by private health insurance.
- Data relating to booking fees is not readily available. A quick Google search indicates booking fees tend to be around $2,000-$5,000. This is in addition to out-of-pocket costs for antenatal visits and other related non-admitted services.
- This puts the out-of-pocket costs for a birth in the ballpark of $2,500, at the very top end of average out-of-pocket costs for any category of admission.
- Evidence suggests that the number of births covered under private health insurance has fallen over the last couple of years. It is possible that this change is the start of a trend. It is

not possible to say whether this change is due to high out-of-pocket costs, but it has been suggested that this is a key contributing factor.

- This change is significant for the private health sector for two reasons:
  - Obstetric services – a reduction in the number of privately insured births will mean less demand for private obstetrician services. There have been recent reports of private obstetricians advertising their services, which is previously unheard of. In a standard market, a reduction in demand would typically lead to a reduction in price.
  - Private health insurance and other providers – consumers often first purchase private health insurance at the "family formation" stage, and then retain their membership following the birth. If consumers are less likely to birth as privately insured patients, then they may be less likely to enter the private health insurance market at all. This would reduce the insured pool of consumers, and logically lead to a reduction in demand for privately delivered health services overall.

Industry-led Initiatives

The Commonwealth encourages a sector-wide approach to developing sustainable solutions in the private health industry. When industry identifies issues and has the capacity and expertise to influence positive outcomes, the Commonwealth is supportive of industry taking the initiative to deliver solutions. This is in line with the Commonwealth's deregulatory agenda. Private health insurers and medical associations have issued public statements in support of fee transparency, highlighting excessive fees charged by a minority of medical specialists. Several insurers have recently started to publish fee data online for their members. Some examples of industry-led initiatives are provided below.

Royal Australasian College of Surgeons – Complaints Service

The Royal Australasian College of Surgeons (RACS) voluntary Code of Conduct recommends that "the surgeon ensures that the fee is reasonable and does not exploit a patient's need. It is a breach of the Code of Conduct to take financial advantage of a patient. RACS is not prescribing fees or mandating any schedule of fees, but is requiring full disclosure and transparency".[5]

RACS can receive complaints from patients who feel they have been charged unreasonable fees. RACS will assess and manage complaints and seek an explanation from the surgeon involved. The Professional Conduct Committee will review the surgeon's response and make a decision about how to respond.

Royal Australasian College of Surgeons/Medibank Reports on Surgical Variance

Under this collaboration, Medibank provides RACS with de-identified administrative data, and RACS then applies its expertise to analyse and interpret the information to produce a meaningful report for surgeons. Reports identify average out-of-pocket costs for each surgeon. While specific surgeons are not identified in these reports, doctors are able to request their personal data so they can assess their position in the market.

Reports have been published on general surgery, urology, vascular, orthopaedic, and ear, nose and throat surgery.

[5] Division: Fellowship and Standards Document Owner: Director, Fellowship and Standards Authorised By: Professional Development and Standards Board Original Issue: June 2013

Whitecoat Initiative
Whitecoat is a healthcare provider directory and customer review website that helps consumers find, choose and review healthcare providers based on their service experience. The Whitecoat initiative is a joint venture between nib, HBF and Bupa. The Whitecoat initiative is in line with the Australian Government's objective to empower consumers to make informed decisions

Options

This section considers possible options for change, and pros and cons of each. The options presented are intended to guide and encourage discussion, they are not exhaustive.
Several general issues arise from the options presented below:

- options which reduce out-of-pocket costs by increasing premiums may reduce the perceived overall value of private health insurance. This is particularly the case given that reduced out-of-pocket costs affect only those consumers who claim, whereas increased premiums affect all people covered.
- doctor's incomes are made up of several components: MBS benefits, private health insurance benefits, out-of-pocket costs. Some options would increase doctors' incomes through increased MBS and private health insurance benefits. Doctors would still be able to set their out-of-pocket costs, and they may choose to increase their total income rather than reduce patients' out-of-pocket costs. Therefore, these options would not necessarily lead to a reduction in out-of-pocket costs.
- options which may reduce out-of-pocket costs do not necessarily increase levels of informed financial consent. Consumers may still face unexpected costs.

Option 1 – Increase Medicare Benefits Schedule fees and benefits

Description: Commonwealth to increase MBS fees.	
Pros	**Cons**
• May lead to lower out-of-pocket costs for the consumer	• Increase in costs for the Commonwealth and insurers • Doctors may choose to increase fees so out-of-pocket costs don't change • Insurers may respond by reducing gap payments so out-of-pocket costs don't change
Other Considerations: This is unlikely given current fiscal circumstances.	

Option 2 – Increase number of no/known gap arrangements

Description: Increase the number of no/known gap arrangements between insurers and doctors.	
Pros	**Cons**
• May lead to lower out-of-pocket costs for consumers • May increase the range of specialist services covered by no/known gap arrangements	• Doctors can choose to use no/known gap arrangements on a patient-by-patient basis • Cannot be enforced as not regulated • Increase in cost to insurer • Expected premium increases
Other Considerations: Participation in no/known gap arrangements is essentially a decision for individual practitioners.	

Option 3 – Increase amounts paid under no/known gap arrangements

Description: Insurers increase benefits paid through no/known gap arrangements, replacing some/all out-of-pocket costs.	
Pros	**Cons**
• May lead to lower out-of-pocket costs for consumers • May encourage more doctors to use no/known gap arrangements	• Doctors can choose to use no/known gap arrangements on a patient-by-patient basis • Doctors may accept the higher known gap benefits without reducing patients' out-of-pocket costs • Cannot be enforced as not regulated • Increase in cost to insurer • Expected premium increases
Other Considerations: Participation in no/known gap arrangements is essentially a decision for individual practitioners.	

Option 4 – Impose limits on out-of-pocket costs

Description: Limit out-of-pocket costs through regulation or voluntary arrangements.	
Pros	**Cons**
• Would reduce out-of-pocket costs for consumers • May lead to an increase in the number of health insurance policies due to reduced out-of-pocket costs • Health insurance may be better value for consumers	• Would be strongly opposed by clinicians
Other Considerations: There is a widely held view that the Commonwealth cannot regulate doctors' fees. However, it may be open to the Commonwealth to regulate access to private health insurance benefits dependent upon conditions related to out-of-pocket costs. Alternatively, in the interests of long-term sustainability, the private health industry could voluntarily introduce an agreement or code of conduct to implement a standard fee system and reduce out-of-pocket costs.	

Option 5 – Provide more information for consumers

Description: Make information about doctors' fees readily available to consumers. Encourage consumers to ask the appropriate questions of their doctors.	
Pros	**Cons**
• Consumers would be able to easily access and compare doctors' fees/out-of-pocket costs/no or known gap arrangements • Consumers would not require multiple doctor visits/referrals to compare costs • By educating consumers, they will be encouraged to ask the right questions regarding their health care costs • Making doctors' fees publicly available may encourage doctors at the higher end of the pay scale to reduce their fees • May lead to reduced out-of-pocket costs for an individual consumer if they have information about doctors' fees and the ability to change doctors easily	• Making information about doctors' fees publicly available may contribute to an increase in fees from doctors at the lower end of the pay scale
Other Considerations: Education would be most effective if it could be targeted at consumers who will be using hospital services. Under current arrangements, insurers are often not aware of an intended hospital visit until late in the process.	

Option 6 – Work with GPs on referrals, provide greater transparency to GPs

Description: Encourage GPs to consider costs when referring patients to specialists, while not interfering with clinical decisions.	
Pros	**Cons**
• May lead to reduced out-of-pocket costs for the consumer • Consumers would be more informed at the time of referral	• GPs may feel conflicted about having a "financial" role
Other Considerations: Would require information about specialists' costs to be more readily available.	

Option 7 – Renew focus on Informed Financial Consent (IFC) policy

Description: Increase the proportion of patients who genuinely provide informed financial consent.	
Pros	**Cons**
• Provides patients with information about their expected costs	• Does not address the level of out-of-pocket costs • Does not help patients judge whether costs are reasonable • Doctors may include fees for additional time for IFC
Other Considerations: Anecdotal evidence suggests levels of IFC are already relatively high. However, in many cases, "consent" may be a formality only; while patients may be made aware of expected fees, this is a process of "information giving" rather than active consent.	

Option 8 – Introduce single billing for all hospital services

Description: All hospital and medical costs for an episode would be bundled into a single bill	
Pros	**Cons**
• Simplifies administration for patient	• Is likely to be strongly opposed by clinicians
Other Considerations: Hospitals could bill on behalf of doctors, or they could contract doctors and charge patients an episodic fee.	