Out-of-pocket expenses from A to Z

Australian Society of Ophthalmologists

We keep hearing about out-of-pocket medical expenses, but with so much commentary on the issue what and who can you believe?

The following document is intended to inform discussion on out-of-pocket medical expenses in the "real" world; which means we need to address three key areas:

1. **Health Insurer related out-of-pocket expenses**
2. **Surgeon related out-of-pocket expenses**
3. **The need for improved advice for consumers**

1. Health Insurer related out-of-pocket expenses

Differential rebating

Differential rebating is essentially the practice by which Private Health Insurers pay a minimum rebate to some patients, compared with others who have an identical policy.

Health insurers pay different rebates for a patient service according to whether the patient sees a contracted health fund doctor or an independent surgeon.

Thus, by merely exercising their right of choice there are patients who incur increased out-of-pocket expenses despite having an identical health policy to another patient.

Health insurers have the ability to penalise patients with a differential rebate based on the fee a patient's chosen surgeon charges.

Health insurers will pay a maximum private rebate to patients whose doctor charges less than $400-500 above the 'no-gap' fee.

If a doctor charges more than this amount the health fund may penalise a patient by only applying a minimum rebate. Thus, two patients with an identical health policy could be rebated differently according to what their doctor charges.

The Australian Society of Ophthalmology (ASO) is proposing that, in order to minimise out-of-pocket costs for patients, all patients receive an equal rebate regardless of which surgeon they see and what their surgeon charges. This would bring an end to differential rebating.

Worked example:
Dr A Fee $1600. Patient rebate $1200 (Medicare $700+PHI $500). Out-of-pocket cost $400
Dr B Fee $1605. Patient rebate $825 (Medicare $700+PHI $125). Out-of-pocket cost $775
In this example seeing a doctor who charges only $5 more but is on the wrong side of the cut-off almost doubles the patient's out-of-pocket cost.

Insurers use this tactic to minimise their exposure to rebates, but it unfortunately maximises the out-of-pocket expenses incurred by patients.

Medicare indexing

When Medicare rebates are frozen or cut, Private Health Insurers adjust their rebate in-line with the rebate change.
Thus, a Medicare rebate change of 5% is mirrored by the Private Health Insurer and a private patient receives a "double whammy" cut to their rebate.

Junk policies

The rise of junk policies have been identified as a major problem for consumers purchasing private health insurance. A junk policy is a nickname

for a type of low-cost cover that only provides cover for a small range of procedures, or perhaps only covers you in a public hospital. If the policy information doesn't accurately represent the value you think you are getting, then you might find you're not covered when it comes time to make a claim. Consumers are regularly unable to decipher the complex descriptions and exclusions of their private health cover.

Hospital readmission and 'complications'

There is a growing trend for Private Health Insurers to disallow claims for readmission within 28 days. This is usually negotiated within the hospital contracting agreement and there is a good likelihood that patients will not be covered for medical expenses from the surgeon within that time interval.

The negotiation is asymmetric with the power being held by Private Health Insurers who can award a hospital contract or not based on their own definition of 'complication'. The Medibank Private dispute with Calvary Hospital Group over contract arrangements that occurred in 2015 highlighted this issue.

Private Health Insurers can claim that they should not be responsible for 'medical complications', but such events — though unfortunate — are an unavoidable part of many surgeries (e.g. the occurrence of bleeding, post operative infections, and situations requiring return to theatre).

The definition of 'complications' by Private Health Insurers has been blurred through the use of their own descriptor 'medical mishaps'. 'Mishap' denotes a surgeon or hospital mistake, yet health funds have attempted to include routine 'complications' such as blood loss or blood clot or infection in this.

If the trend continues the potential grows for:

- Readmitted patients to face the possibility of being uninsured at no fault of their own at a time of great need and then incur large and unexpected out-of-pocket medical expenses
- Private hospitals to refuse to operate on more complex patients for fear of complications (in order to avoid an uninsured patient readmission).
- delayed readmission which may produce an adverse outcome due to delayed treatment. The hospital which is not being paid by the Private Health Insurer for the readmission might be reluctant to readmit unless absolutely necessary. In short, readmission must be available without any barriers and based only on true clinical need — never with winners and losers.

Day Surgery de-contracting

30% of Day surgeries reported having their contracts with Private Health Insurance providers cancelled for non-medical reasons last year.

This leaves patients with increased hospital gap costs.

This also limits choice of day surgery for patients, especially those patients residing in non-urban areas.

2. Surgeon related issues

Procedural fees

Patients who have unexpected shocks with out-of-pocket medical expenses are usually the ones who have not been provided with adequate Informed financial consent (IFC). It is essential that no patient proceed with surgery without a written financial document.

In our opinion, the focus on widespread 'overcharging', however it might be defined, has been exaggerated. The majority of patients have a 'no gap' or 'low gap' procedure (87% no gap, 7% known gap) and yet there are cases where patients are significantly out-of-pocket. These cases of egregious overcharging are usually statistical outliers but they do pose a reputation problem for surgeons.

In general, surgeons in the Eastern states are more likely to charge out-of-pocket costs than surgeons in the Southern and Western states, which reflects the very different cost of living and housing across Australia.

n.b. From time to time we see 'Overseas Medical Tourism' promoted, however it would be wise to first investigate interstate medical tourism as an alternative. Another alternative would be for patients to investigate different surgeons in other regions of their capital cities.

Reluctance of surgeons to accept Private Health Insurer gap contracts

Surgeons are unlikely to sign up to Private Health Insurer contract arrangements because the fees are often regarded as commercially unacceptable. Furthermore, these contracts can be restrictive and sometimes seek to 'lock in' surgeons to provide 'no gap' procedures on <u>all</u> patients once the contract is signed.

Some contracts make it compulsory to allow the Private Health Insurer to audit a surgeon's records.

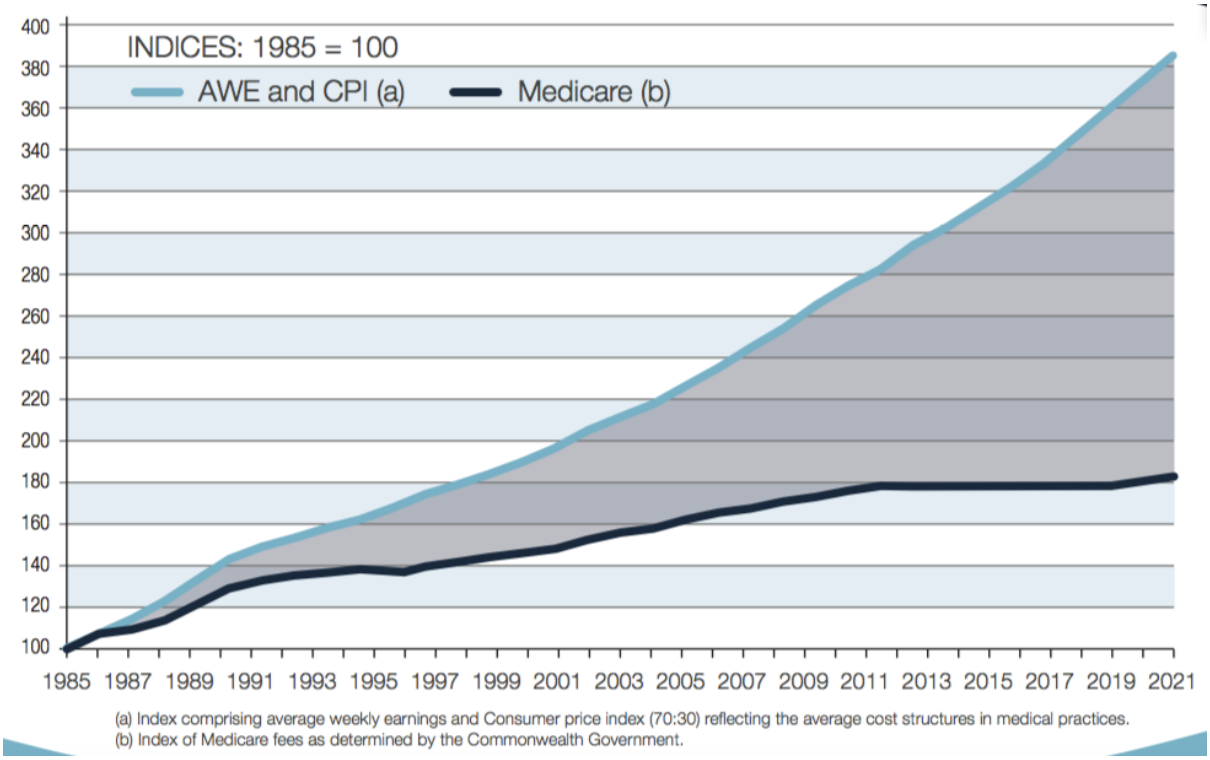
Some contracts make it mandatory to perform 'no gap' procedures at certain hospitals

Some contracts are offered to Day Surgeries only if they force doctors to charge 'no gap' which would cause the day surgery to lose many of its visiting surgeons.

In summary, few people in this world choose 'lock in' contracts that impose terms and conditions which restrict freedoms of commerce and invite intrusion into a private business.

Medicare rebate freeze and rebate cuts

The Australian Medical Association (AMA, 2016) graph provided below says it all. Medicare has been indexed at just 2.1% since 1985. It is inevitable that gaps grow when health provider costs rise at 5-9% per annum, greater than the CPI.



Source: Australian Medical Association Indexation Freeze Gaps Poster 2016

New and revolutionary technologies

New and revolutionary technologies are a part of any industry. As these technologies become available to medical specialists they utilise them in their practice. Often these are expensive and additional costs are not covered by private insurance.

New technologies are not always proven to be superior so it is acceptable that Private Health Insurers don't routinely fund them. However, when a patient requests this technology, or if a surgeon prefers the assistance of this technology in the belief that it improves performance there can be high out-of-pocket medical expenses e.g. DaVinci Prostatectomy robot.

Most patients ask for the "best and latest". However, we know that in any sphere, whether it is iPhones or computers, the latest model is the most expensive and may in the medical context cost more.

The rise of Dr Google and medical consumerism has made patients extremely aware of scientific advances but it has also made them unwittingly susceptible to marketing dressed up as medical advice.

Listing surgeons' fees online

Whilst apparently plausible there are several problems with the concept of surgeons' fees being readily available online.

- The Council of Procedural Specialists (COPS) has previously applied to the ACCC for permission to list surgeon's fees. The ACCC ruled against this practice on the basis that it reduces competition by setting a standard fee around which all competitors would cluster.
- It is difficult for a surgeon to give a quote on a surgical problem which has not been assessed. Unknown variables include:
    - which item numbers will apply in a specific case,
    - what materials and technologies will be used,

- how different funds will rebate on different circumstances,
- what level of insurance a patient holds,
- whether the patient would qualify for a compassionate discounting of fees which is common and only assessable in person
- what complexity of surgical intervention is required

- There is a strong chance of doctors "gaming" the system — whereby a doctor would advertise a lowball rate to win work but has not included all of the possible additional expenses that commonly apply in his/her fee
- To be effective, a website listing surgeons' fees would need to list what is included and excluded from the treatment. It would also require a field to allow a surgeon to make specific comments about their offering.
- Be aware that at medical conferences even the experts disagree on which technique or technology is best, therefore a patient has little chance of judging this for themselves without any of the perspective a trained doctor has gained through years of experience.

The need for improved advice for consumers

Informed financial consent (IFC) is the provision of cost information to patients, including notification of likely out-of-pocket expenses (gaps), by all relevant service providers, preferably in writing, prior to admission to hospital or treatment.

ASO proposes the introduction of mandatory IFC via a signed form for all patients.

Patients should also be made aware that they are under no obligation to accept an IFC which they find prohibitive. They should be encouraged to seek a second opinion, possibly out of suburb, city or region.
The AMA guide to surgical fees is still regarded as a good guide to maximum fees. The AMA fee guide has followed CPI increases since the inception of Medicare and has been unaffected by rebate freezes or reductions.

Patients can also seek the advice of a friend or GP who has knowledge of a surgeon's billing attitudes.

Patients need to be encouraged to check their insurance cover to avoid 'junk policies' and exclusions.