Out-of-pocket medical expenses

- A guide for consumers

Background and stimulus document developed by **Dr Peter Sumich** submitted to the 'Out of pocket (OOP) and Fee Transparency roundtable' to be held on 12 June 2018 at the University of Melbourne.

Introduction

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 (OOP) medical expenses in the "real" world; which means we need to address three key areas:

1. **Private health insurer related out-of-pocket expenses**
2. **Surgeon related out-of-pocket expenses**
3. **The need for improved advice for consumers**

1. Private health insurer related out-of-pocket expenses

1.1 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. Insurers pay different rebates for a patient service according to whether the patient sees a contracted health fund doctor or depending on a surgeon's fees.

If the surgeon doesn't charge according to the Gap Cover fee schedule, then the patient receives the minimum benefit only (and the patient ends up with a larger OOP expense with minimal help from the health insurer).

Worked example:

Dr A. *Dr A Fee $1600. Patient rebate $1200 (Medicare $700+PHI $500).* ***Out-of-pocket cost $400***

Dr B. *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.

Recommendation

In order to minimise out-of-pocket costs for patients, all patients should receive an equal rebate regardless of which surgeon they see and what their surgeon charges. This would significantly reduce OOP expenses, and all insured patients would be treated equally.

1.2 Inadequate co-payment growth and gap cover 'cut outs'

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

If a doctor charges more than this amount, the health fund will only allow the minimum rebate and the patient will receive no 'gap' assistance resulting in a larger OOP expense. Thus, two patients with an identical health policy could be rebated differently according to what their doctor charges.

Recommendation

The co-payment amount has not been indexed (increased) at all in 20 years. It should be increased by 50% to allow a patient's surgery bill to fall within the allowable amount. This will reduce OOP expenses for patients by maximising the amount a health insurer contributes.

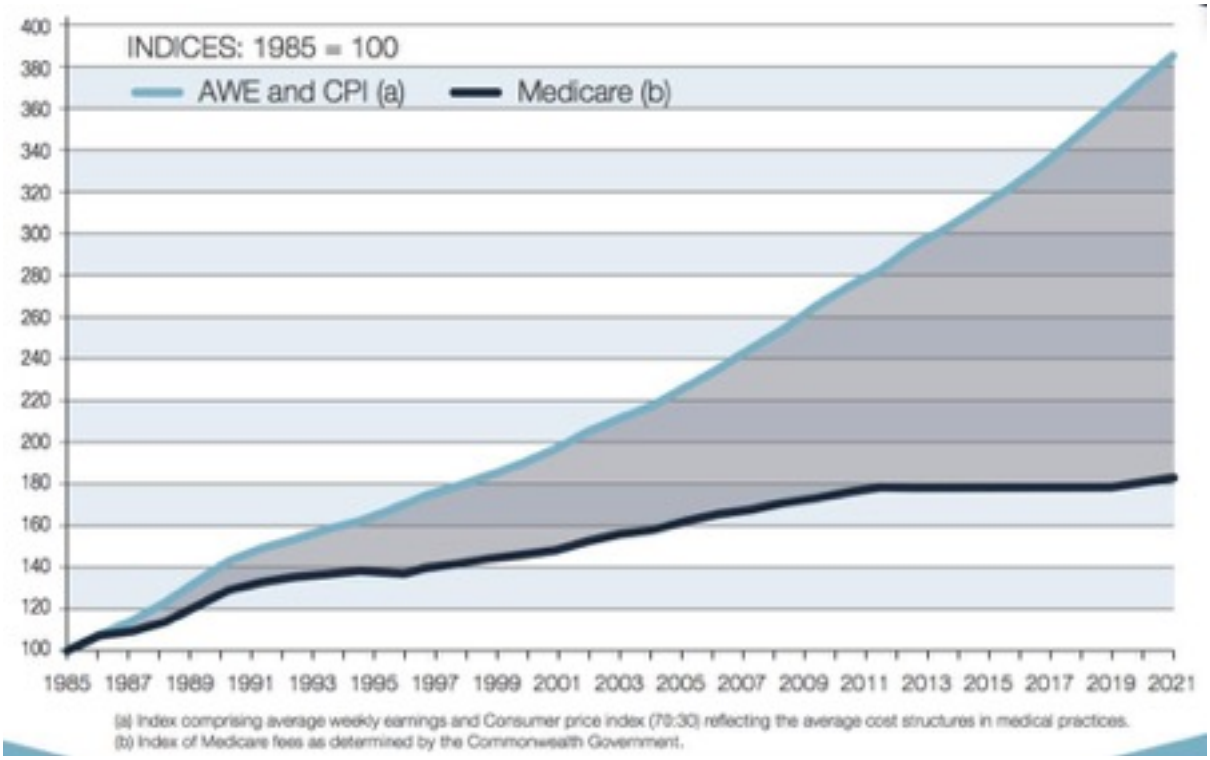
1.3 Medicare and private health insurer indexing

Private health insurers index (increase) their rebates in-line with Medicare.

Whenever Medicare is not adequately indexed or is frozen or cut, private health insurers mirror the trend.

Thus, a Medicare rebate cut of 5% is mirrored by the private health insurer and a private patient receives a "double whammy" cut to their rebate — losing both the Medicare amount and the private insurer amount.

The following graph shows how Medicare (and thus private rebates) have fallen behind in the last 30 years.



Recommendation

Private health insurers should index (increase) their private rebates at the CPI rather than the Medicare indexing which is not at CPI.

1.4 Low value insurance (junk policies)

The rise of junk policies has 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.

Recommendation

Classification of policies into easily decipherable categories to improve transparency and ease of comparison as per the Federal Government's new system of categorisation due to be rolled out in April 2019 (with Gold, Silver, Bronze, Basic levels of cover).

Patients will be best served if they purchase comprehensive insurance…this is the eternal challenge.

1.5 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.

Private Health Insurers can claim that they should not be responsible for 'medical complications', but such events — though unfortunate and uncommon — 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 with the use of the descriptor 'medical mishaps'. 'Mishap' implies a surgeon or hospital mistake, yet health funds include accepted 'complications' within this definition.

This can significantly impact out-of-pocket expenses:

- Readmitted patients may face the possibility of being uninsured at no fault of their own, or their doctor's, at a time of great need — and then incur large and unexpected out-of-pocket medical expenses, and
- Private hospitals may refuse to operate on more complex patients for fear of complications (in order to avoid an uninsured patient readmission).

Recommendation

Patients should be able to insure for readmission within 28 days.

1.6 Day surgery de-contracting

In 2017 about 30% of day surgeries reported having their contracts with private health insurance providers cancelled for non-medical reasons.

This is a situation that ultimately disadvantages patients.

- They can be left with increased hospital OOP expenses if the surgeon operates at a non-contracted centre, and
- Their choice of day surgery location is limited.

Recommendation

Private health insurers should cover patients at any day surgery which complies with the Australian Code of Quality Assurance. Only in the most extreme cases should a complying day surgery be de-contracted and a third party opinion sought.

2. Surgeon related out-of-pocket expenses

2.1 Procedural fees

Patients who have unexpected shocks with out-of-pocket medical expenses often have not been provided with adequate Informed financial consent (IFC). With the exception of emergency surgery, it is essential that no patient proceeds with surgery without a written financial document.

Some surgeons are charging fees which are beyond the reasonable fee and unfortunately patients are not always aware of what they should expect to be paying.

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

Recommendation

- Patients should always be provided with an informed financial consent before surgery
- Patients should be encouraged to question fees and shop around if uncertain
- Patients should not equate higher fees to higher quality
- The AMA Fee is regarded as a full fee and anything significantly above this should be questioned. Patients can enquire whether the doctor is above the AMA fee and he/she should be able to tell the patient.

2.2. Reluctance of surgeons to accept Private Health Insurer gap contracts

Surgeons are reluctant to sign up to private health insurer contract arrangements because the fees are often regarded as commercially unacceptable. This is, of course, a matter of great debate between insurers and doctors (as one might expect in a commercial setting). It is again important to note that private health insurance fund fees have been indexed in line with Medicare, not CPI, and have thus diverged from the true cost of providing medical services for decades.

Furthermore, health fund contracts can be restrictive and sometimes seek to 'lock in' surgeons to provide 'no gap' procedures on all patients once the contract is signed. Some contracts make it compulsory to allow the private health insurer to audit a surgeon's records which doctors feel is an unwarranted intrusion. Insurers, however, would argue that they should be able to ensure that claiming is appropriately policed.

Some contracts make it mandatory to perform 'no gap' procedures at certain hospitals. Doctors reject this as undue control, but insurers would claim it allows them to control fees.

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 — so the day surgeries remain uncontracted, increasing patient out-of-pocket expenses to make up for the shortfall from the contracted theatre fee.
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.

2.3 Medicare rebate freeze and rebate cuts

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

Recommendation

More realistic indexing (increase) of the Medicare rebate, to at least bring it in line with CPI, even though this still falls short of medical expense CPI.

2.4 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 health insurance and patients will need to pay them.
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. the DaVinci robot, which is used for prostatectomy and a number of other procedures. Most patients ask for the "best and latest". However, we know that in any sphere, whether it is smartphones 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.

2.5 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 surgeons' 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.

Paradoxically it might cause some surgeons to increase their fees if their competitors are charging more.

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 fee, which is common and only assessable in person
- what complexity of surgical intervention is required.

There is a strong chance of some 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 that a trained doctor has gained through years of experience.

3. The need for improved advice for consumers

3.1 Informed Financial Consent

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 this occurs in writing, prior to admission to hospital or treatment.

Recommendation

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 unacceptable. They should be encouraged to seek a second opinion, possibly out of suburb, city or region. Patients should be encouraged to seek the advice of a friend or GP who has knowledge of a surgeon's billing attitudes. Word of mouth is very reliable in locating a good doctor at a good price point.

3.2 AMA fee guide

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.

Recommendation

Patients should be encouraged to ask a doctor whether his/her fee is more than the AMA fee.