We are hirmaa

27 January 2017

Committee Secretary
Community Affairs Reference Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee Secretary

Re: Senate Inquiry into price regulation associated with the Prostheses List Framework

Thank you for the opportunity to comment on the matters as referred to the Community Affairs Reference Committee by the Senate on 21 November 2017.

hirmaa represents 20 community-based private health insurers, comprising both industry or employer focused "restricted access" insurers and "open" insurers serving particular regions. Collectively, hirmaa funds provide health insurance to over one million Australians across the country. hirmaa funds are predominantly not-for-profit and community based, and identify as mutual and/or member-owned insurers.

Since its formation in 1978, hirmaa has advocated for the preservation of competition, believing it to be fundamental to Australians having access to the best value health care services. hirmaa has done this by:

- promoting legislation, regulations, policies and practices which increase the capacity of its member organisations to deliver best value health care services; and,
- advocating for the preservation of a competitive market, which we see as essential to the integrity and viability of the PHI industry.

hirmaa funds, which are not-for-profit, member-owned and community based organisations, play a crucial role in upholding the competitiveness of the private health insurance market place.

We are pleased to provide the following response to the terms of reference given to the Committee.

Yours sincerely

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Senate Inquiry into price regulation associated with the Prostheses List Framework

EXECUTIVE SUMMARY

One of the key drivers of health inflation in the private healthcare system is the unsustainable cost of prostheses. Costs associated with prostheses are underpinned by poor government regulation and oversight, and the result is that prostheses prices in Australian private hospital setting are amongst the highest in the world, severely damaging the affordability of private health insurance and unnecessarily costing taxpayers hundreds of millions of dollars through the Australian Government Rebate.

In the 2013-14 financial year, $1.74 billion in benefits were paid for prostheses, representing 14.1% of all benefits paid. In 2015-16 this grew to almost $2 billion.

hirmaa acknowledges the need to fully accommodate legitimate growth utilisation for prostheses, however, the current regulatory pricing framework operated by the Department through the Prostheses List is not set on a sound, prudent, or equitable basis.

This pricing framework mandates fixed benefits for prostheses in the private hospital system that are not systematically assessed, nor set on value based principles or the principles of supply competition. Further, benefits are not subject to regular reviews that would reflect changes in relative performance of prostheses, advances or changes in health services and treatments, or advancements in the manufacturing costs and the production of prostheses that typically drive cost reductions.

Pricing norms in the Australian public sector and internationally do not appear to have any correlation to the benefit level set for prostheses in the Australian private hospital setting under the current regulatory system. This is consistent with established evidence which shows that Australian consumers are being charged up to 300% more for some items than would be paid in comparable health jurisdictions overseas.

Notably, this pricing mechanism is not mandated for public hospitals which are able to access identical classes and models of prostheses at lower prices by utilizing the open market.

The effect of the Prostheses List is such that the difference between projected benefits that will be paid for prostheses for privately insured patients in 2016-17, and what would have been the case if public sector rates had of been utilized, is estimated at $882,743,381.

For holders of the 5,512,365 hospital treatment health policies across Australia, this represents an average difference in cost of $160.

On the current projections, this is expected to exceed $1 Billion in 2018-19, representing an average difference in cost of $181.

hirmaa welcome initial reform efforts undertaken by the previous Minister for Health, however firmly believe that more needs to be done.

Specifically, we believe that the current system is unsustainable and requires significant reform to increase transparency and accountability to ensure the equitable setting of benefits for prostheses.

hirmaa congratulates the Senate on adopting this inquiry into price regulation associated with the Prostheses List Framework, and we remain committed to working with Government to ensure that private health insurance is accessible and affordable.

hirmaa submission to Senate Inquiry into price regulation associated with the Prostheses List Framework

hirmaa is pleased to comment on the following items listed in the terms of reference associated with the Senate Inquiry into price regulation associated with the Prostheses List Framework, and congratulates the Senate for initiating this important inquiry.

a. The operation of relevant legislative and regulatory instruments

The Private Health Insurance (Prostheses Rules) and the Private Health Insurance Act 2007, requires private health insurers to pay mandatory benefits for a range of prostheses items where a Medicare benefit is payable for the associated hospital service.

The Minister for Health sets prices for prostheses through the 'Prostheses List' based on the advice from the Prosthesis List Advisory Committee (PLAC) which is comprised of a range of industry representatives and experts and is aligned with the Department of Health.

When a device sponsor seeks to add an additional item to the Prostheses List an application must be lodged and reviewed by the PLAC. As part of the assessment process, the item will be allocated to a group/sub-group (comprised of prostheses of similar type and clinical effectiveness) on the Prostheses List. With the exception of prostheses carrying a 'superior clinical performance' suffix, prostheses grouped together each have the same benefit level.

However, the premise upon which benefit levels are determined for the more than 10,000 products on the Prostheses List is unclear.

From 2001 to 2005, partial deregulation of benefits-setting for prostheses (insurers were allowed to negotiate benefit levels with hospitals and device sponsors with a condition on the benefit being that patients could not have an out-of-pocket expense) resulted in significant average benefit level inflation and individual benefit amounts set for each item on the Prostheses List (which was administratively complex, time consuming and costly).

The underlying basis upon which the benefit amounts were negotiated and determined is unknown. It can reasonably be assumed that device sponsors were advantaged by the conditions placed on needing to arrive at a benefit level for each prosthesis which would eliminate out-of-pocket expense exposure for patients and on needing to have benefit levels set for all qualifying prostheses.

In 2005, the benefits-setting arrangements were re-regulated, which stemmed but did not reverse the inflation. Minimum and maximum benefit levels for each prosthesis were grand parented from the period of partial deregulation. PLAC's predecessor body, the Prostheses

and Devices Committee (PDC) set about the task of systematically reviewing all the benefit levels. Prostheses of similar type and clinical effectiveness began to be grouped and benefit negotiations with device sponsors were undertaken to reduce variances in benefit levels within each group. As with the preceding period, the underlying basis upon which the benefit amounts were negotiated and determined is unknown.

Following recommendations from the Doyle report, the grouping process was accelerated and a single benefit level was established for each group/sub-group on the Prostheses List (from 2010). Each group's benefit level was set at a benefit amount which aligned with the benefit amount for a product or average benefit amount for products which, at the time the group benefit was established, commanded a minimum of 25% of volume share for that group of prostheses. This was an expedited process to eliminate the costly, labour and time intensive process of negotiating benefit levels with device sponsors for each listed prosthesis. However, this process further locked in and muddied the opaque basis upon which benefit levels were determined during the precedent years.

Thus, there is no evidence to suggest that the benefit levels set for the items on the Prostheses List (especially items grand parented from the period of partial deregulation and items listed since then with benefit levels predicated on the grand parented items) were established on value-based principles, through exercise of competitive levers, or the real cost of manufacture and supply.

Furthermore, since 2010, the benefit levels for the more than 10,000 products on the Prostheses List have not been regularly or systematically reviewed to reflect changes in relative clinical effectiveness, changes in relative cost effectiveness and efficiencies associated with innovations in prostheses design and/ or manufacturing.

For example, if a new device sponsor makes available a cheaper version of a device already on the list, there is no incentive for the sponsor to offer a lower price than the benefit set by the current benefits-setting process.

There is, however, an incentive for device sponsors to engage in activities directly with private hospitals to influence decision making, such as offering volume discounts and rebates, none of which are passed along to the payer (insurers) to relieve premium pressures on consumers.

These perverse incentives appear to have been acted upon as outlined by prostheses and medical devices supplier Applied Medical, which noted in a submission to the Australian Governments Competition Policy Review released in March 2015 that:

> *Customers have explicitly stated to Applied Medical that unless it also provides such hidden rebates or kickbacks, there is no incentive for the hospital to use its products.*

and:

> *the current structure significantly impedes the ability of a supplier reluctant to engage in hidden rebating.*[1]

[1] Applied Medical, Submission to Draft Report, 'Competition Policy Review', 2014, pg. 11

b. Opportunities for creating a more competitive basis for the purchase and reimbursement of prostheses.

There is an opportunity to improve the competitive basis for the purchase and reimbursement of prostheses through the review of the '25% market share rule' and the development of a National Prostheses Purchasing Authority.

Modifying the 25% market share rule

The existing market structure for prostheses and medical devices requires a 25% market share, or 'utilization rate' to set the minimum benefit limit for a sub-group as a whole.

This model provides an unfair advantage to existing entities within the market and serves as a barrier against new entrants and the innovation, that can be achieved through enhanced competition.

In its submission to the Australian Government's Competition Policy Review released in March 2015, prostheses and medical devices supplier Applied Medical noted that:

> *...the 25% utilization rate threshold actually acts to prevent innovation amongst suppliers to supply prostheses at lower costs to Australian patients*

and that

> *This also means that the ability of an innovative, ethical competitor, willing to supply at a much lower benefit level, to influence the group benefit level, is severely restricted.*

The 25% market share rule should be amended to benefit those who are *able* to meet the 25% threshold as opposed to those already there. Such a change would ensure that large manufacturers with the infrastructure at hand to generate the requisite supply are able to better compete in the space and facilitate the addition of further innovation and cost competition in the sector.

National Prostheses Purchasing Authority

At present, several state jurisdictions operate central procurement agencies/ authorities which exist to maximize price advantages derived from the bulk acquisition of commonly used goods and services.

For example, in Victoria, Health Purchasing Victoria (HPV) is responsible for managing contracts totaling $776.9 million on behalf of 27 participating health services[2]. HPV's purpose is to improve the collective purchasing power of Victorian public health services and hospitals through achieving 'best value' outcomes in the procurement of health-related goods, services and equipment across 48 contract categories, and in the 2015-16 year was able to leverage $96.2 million in benefits (incorporating cost reduction, cost avoidance and further opportunities).

There is an opportunity to utilise such an entity on a national scale to drive even greater savings in the prostheses and medical devices market by combining the market power of both Public

[2] Health Purchasing Victoria – Annual Report 2015-16, pg. 13

and Private Hospitals.

Such a national entity would incorporate best practice standards derived from existing examples from Australia and internationally, and could be established and supported by a federation model of health jurisdictions or centrally by the Commonwealth Government.

Given the anticipated volume of devices purchased by a national authority, covering public and private sectors, it would be reasonable to assume a significant reduction in prices across both sectors. Additionally, the present administrative burden of both private and public hospitals would be reduced substantively.

The work of a National Prostheses Purchasing Authority should also adopt a reference pricing mechanism to facilitate international benchmarking.

c. The role and function of the Prostheses List Advisory Committee and its subcommittees.

As outlined in response to item 'a.' the origianal Prostheses Lisat Advisory Committee (PLAC) was established established in response to surging prostheses costs between 2001 to 2005 following the partial deregulation of the benefits-setting for prostheses.

In 2005, the benefits-setting arrangements were re-regulated, which stemmed but did not reverse cost inflation with the minimum and maximum benefit levels for each prosthesis grand parented, locking in levels from the high cost period of partial deregulation.

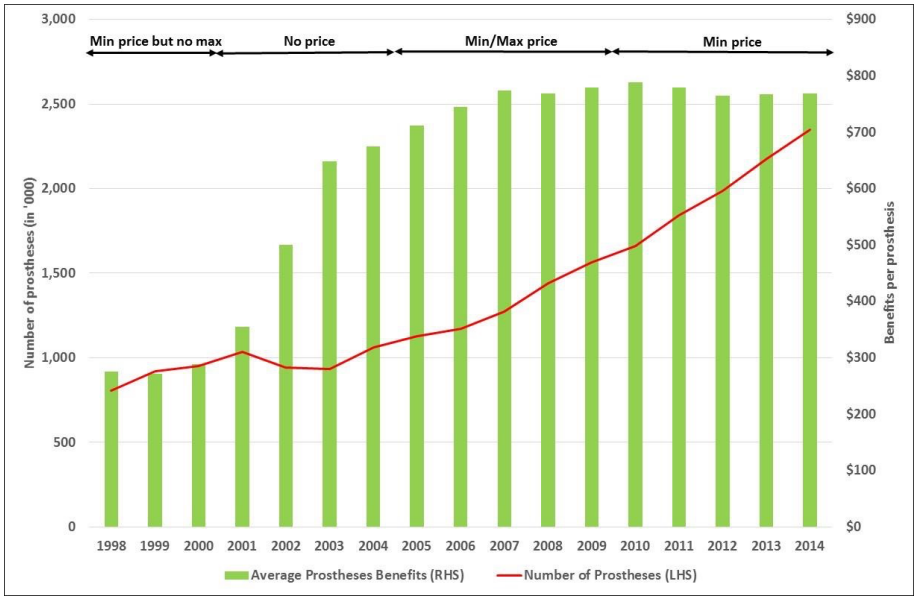
PLAC's predecessor body, the Prostheses and Devices Committee (PDC) set about the task of systematically reviewing all the benefit levels and determined to group devices into categories for negotiation, the underlying basis upon which the benefit amounts were negotiated and determined is unknown.

Following recommendations from the Doyle report, this grouping process was accelerated and a single benefit level was established for each group/sub-group on the Prostheses List (from 2010), this simplified the the costly, labour and time intensive process of negotiating benefit levels with device sponsors for each listed prosthesis. However, this process further locked in and muddied the opaque basis upon which benefit levels were determined during the precedent years.

Since this time the benefit levels for the more than 10,000 products on the Prostheses List have not been regularly or systematically reviewed to reflect changes in relative clinical effectiveness, changes in relative cost effectiveness and efficiencies associated with innovations in prostheses design and/ or manufacturing.

With these high settings locked in the average annual growth in the volume of prostheses used increased by 9.7 per cent per annum over the period 2003 to 2014, placing considerable cost pressures on patients and private health insurance providers.[3]

[3] Australian Government, Trends in Hospital Accommodation, Medical Services and Prostheses- Statistical Bulletin, June 2015.



Source: Trends on hospital accommodation, medical services and prostheses: Private Health Insurance Administration Council, Chart 1 (PHIAC).[4]

As such, the role and function of the PLAC and its subcommittees, was entirely insufficient for the purpose of ensuring value in benefits-setting. The lack of transparency in determining benefits and the inability to undertake reviews of the prostheses benefit categories meant that costs escalated despite competition and innovation in prostheses design and manufacturing processes that resulted in significantly reduced prices internationally and within the public systems in Australia.

Reconstituted Prostheses List Advisory Committee

hirmaa supports the role and function of the Reconstituted Prostheses List Advisory Committee and subcommittees in principle, and endorses the 'purpose' and 'roles and function' as outlined within the Prostheses Lisa Advisory Committee (PLAC) Terms of Reference.

However, it is essential that the reconstituted PLAC learn from the significant shortfalls of its predesesors. Specifically, the committee requires access to a comprehensive suite of information and data such as mandatory price disclosure and reference pricing (international and domestic) which would ensure that the committee is able to effectively and efficiently determine appropriate benefits settings that best serve the interests of the Australian patient and ensure that all stakeholders are able to have full confidence in the system.

There is also a need to ensure that the committee is suitably resourced to be able to undertake reviews of all listed items against evolving market settings as well as further technological and manufacturing advancements. Ideally, this would involve a comprehensive review of benefits settings at intervals of not more than three years.

Obligations and powers required by the committee and its subcommittees to undertake this task should be formally legislated and regulated in a manner consistent with the

[4] Australian Government, Trends in Hospital Accommodation, Medical Services and Prostheses- Statistical Bulletin, op.sit,

Pharmaceutical Benefits Scheme (PBS) which has a proven track record of delivering pricing efficiencies across pharmaceuticals.

d. The cost of medical devices and prostheses and privately insured patients versus public hospital patients and patients in other countries.

At this time there is a significant lack of transparency around the benefit setting process for medical devices and prostheses as paid in the public versus the private hospitals, as well as patients in other comparable countries.

However, on available data it is clear that patients in private hospital settings pay significantly more for life enhansing and live saving prostheses than patients in public hospital settings. This is placing a significant cost burden on holders of private health insurance and is endangering the sustainability of the private health system in Australia.

Public versus Private

The analysis at Attachment A compares the top 20 Diagnosis-Related Groups (DRG's) between public and private hospitals in terms of both volume and unit price, overall the analysis finds that in 2013-14 (the latest year for which this information is publicly available), private hospitals paid approximately $1.17 billion for devices in the top 20 DRG prostheses category while public hospitals paid approximately $683.2 million.

Critically, Private Hospitals paid more than Public Hospitals over all DRGs with the cost difference exceeding 200% in several instances with a total average cost differential, when weighted for casemix, being approximately 71.6%. Put another way, if private hospital prostheses benefits by DRG were equivalent to public hospital costs by DRG over the same period prostheses benefits would reduce by 41.3%.

The data also clearly shows that Private Hospitals generate greater volume, in terms of prostheses use, than public hospitals, with there being more private sector cases in all but three of the top twenty private sector DRGs by prostheses charge.

Greater volume typically translates into lower prices. If normal economics applied the relative volume would indicate significantly lower prostheses charges in the private sector, especially for those DRGs related to hip and knee replacements where the volume in Private Hospitals is much higher than in Public Hospitals. This is clearly not occurring within the current market setting and is a clear and compelling sign of regulatory and market failure.

The estimated cost between prostheses benefits paid to Private Hospitals compared to what they would have been paid in the public system for the 2015-16 year is $824,338,607 (Attachment B).

Also of particular note is the fact that the failure to relieve premium pressure through prostheses reform has cost the Commonwealth Government approximately $672,026,626 through the Australian Government Private Health Insurance Rebate over the last three years.

On the current trend, the cost disparity between prostheses in the private sector versus the public sector is projected to be $882,743,381 in 2016-17, this is expected to increase to $1 Billion in 2018- 19 (Attachment C).

Other counties

In 2015 hirmaa compared various items from the prostheses list with prostheses pricing in France. The analysis found significant price variances on a product versus product basis, with several items on the Prostheses List priced over 300% more than in France (see Attachment D).

e. The impact of the current Prostheses List Framework has on the affordability of private health insurance in Australia.

In the 2013-14 financial year, $1.74 billion in benefits were paid for prostheses, representing 14.1% of all benefits paid. In 2015-16 this grew to an estimated $2 billion representing approximately 14.4% of the average hospital treatment policy (see Attachment E).

The ability to reduce the cost burden of prostheses and medical devices on private health premiums is critical to the sustainability of private health insurance in Australia. This is of particular urgency at a time where the number of Australian's with private health insurance has fallen for the first time in approximately 15 years.

As noted in hirmaa's response to item 'd', of this submission, Attachment A compares the top 20 Diagnosis-Related Groups (DRG's) between public and private hospitals in terms of both volume and unit price, overall the analysis finds that in 2013-14 (the latest year for which this information is publicly available) private Hospitals paid more than Public Hospitals over all DRGs with the cost difference exceeding 200% in several instances. If private hospital prostheses benefits by DRG were equivalent to public hospital costs by DRG over the same period prostheses benefits would reduce by 41.3%.

Projections based on current trends are incorporated in Attachment B and Attachment C. These projections clearly show the continued growth in the cost burden of the current system on Australian private health consumers.

Impact of prostheses cost variation between public and private hospitals

Cost differential for prostheses public vs private	Total difference	Impact on hospital policy premium*
2014-15 (latest publicly available data)	$718,256,536	$130
2015-16 (projected)	$824,338,607	$149.50
2016-17 (projected)	$882,743,381	$160
2017-18 (projected)	$945,286,159	$171.50
2018-19 (projected)	$1,012,260,123	$181

*based on the current number of hospital cover policies

The high cost of prostheses is driving up the cost of private health insurance premiums, damaging affordability and threatening the sustainability of the private health insurance sector,

and with it the private health sector generally.

f. The benefits of reforming the reference pricing system with Australian and international benchmarks.

A comprehensive reference pricing system would help to ensure that international and overseas based device manufacturers do not gauge Australian patients for easily transportable and readily available prostheses and medical devices.

Introducing Reference Pricing

Reference pricing is not a part of the current prostheses benefits setting model, however, significant evidence exists in the public realm to show that such a requirement would result in a reduction in the cost of prostheses while enhancing transparency through the establishment of international benchmarks.

In 2015 hirmaa compared various items from the prostheses list with prostheses pricing in France. The analysis found significant price variances on a product versus product basis, with several items on the Prostheses List priced over 300% more than in France (see Attachment D).

Reference pricing was a prominent issue investigated a wide ranging Industry Working Group on Private Health Insurance Prostheses (IWG), established by the Department of Health in February 2016. The IWG agreed "that reference pricing, taking into account domestic and relevant international prices, be considered as a mechanism to set the PL [Prostheses List] benefit".[5]

Additionally, reference pricing would be of value in circumstances where price disclosure mechanisms would be of limited effect (e.g., single device sponsor device markets).

Such a model would necessitate a minimum fixed period for review, which we suggest should be not more than three years.

g. The benefits of any other pricing mechanism arrangements, including but not limited to those adopted by the Pharmaceutical Benefits Scheme, such as:
   i. mandatory price disclosure,
   ii. value-based pricing, and
   iii. reference pricing.

hirmaa strongly endorses those principles that underpin the Pharmaceutical Benefits Scheme (PBS) and believes that consideration of a PBS equivalent as a national price-setter of prostheses would constitute a strong foundation for pricing reform.

The role of this body would include determining national maximum benefits for all devices provided across all hospitals – public and private. This model has proven highly effective at analyzing supply chains and delivering pharmaceutical products to Australian patients at significant price reductions.

[5] Sansom AO, Industry Working Group on private Health Insurance Prostheses Reform – Final Report, 2016, pg 1

Significantly, the Department has investigated this option and presented an overview of the Pharmaceutical Benefits Scheme (PBS) price disclosure arrangements, noting its potential applicability to prostheses, the IWG noted:

> *The Department presented an overview of the Pharmaceutical Benefits Scheme (PBS) price disclosure arrangements, and noted its potential applicability to prostheses.*[6]

Value based pricing would place an emphasis on achieving successful outcomes that are both beneficial for the patient and more efficient for the health system.

The benefits of a referencing scheme would also be of significant benefit for the efficient setting of prostheses benefits as discussed in item 'f'.

h. Price data and analytics to reveal the extent of, and where costs are being generated within, the supply chain, with a particular focus on the device categories of cardiac, Intra Ocular Lens Systems, hips, knees, spine and trauma.

hirmaa welcomed as an importance first step, the announcement on 19 October 2016 by the former Minister for Health that the cost of medical devices, as set by the Prostheses List, would be reduced by 10 per cent for cardiac devices and intraocular lenses and 7.5 per cent for hip and knee replacements from 20 February 2017. This will reduce costs for insurers by $86 million in the first year, and total $500 million over the next six years.

However, the methodology used to identify these price reduction is not public and there remains a lack of transparency within the system with respect to unit pricing for prostheses and medical devices.

It is clear that these categories represent a minor percentage of overall prostheses utilisation (see Attachment F) but that they dominate the expenditure burden of patients and insurers (see Attachment G).

hirmaa has acknowledged that the savings announced by the Government were described as a 'down payment'. This was of significance to the private health insurance sector given that there is likely to be significant capacity for further reductions in these high cost areas, as well as across the benefits list more broady.

It is critical that the PLAC be resourced, empowered and given access to the information and data necessary to ensure that all benefits settings are made in the best interests of Australian patients and private health policy holders.

i. Other related matters.

<u>Prohibiting rebates and kickbacks</u>

As noted in the previous section of this submission, the combination of a PBS equivalent for

[6] Sansom AO, op.sit, pg 6

the prostheses market and a National Prostheses Purchasing Authority would drive significant savings across the health system in both public and private settings.

It is, however, acknowledged opportunities can often be created to manipulate the purpose and intent of the Prostheses List. The use of rebates and like activities to facilitate financial benefits between a device sponsor, third parties and hospitals should be prohibited under law.

Attachment A: Prostheses DRG volume and cost Public vs. Private

Prostheses DRG volume and cost Public vs Private								
		Private Hospitals (PHDB data 2013-14)		Public Hospitals (NHCDC – public sector data 2013-14 (Round 18))				
ARDRGv7	Description	Number of Private Sector Separations (procedures)	Average private sector prostheses charge	Number of Public Sector Separations (procedures)	Average public sector prostheses cost	Total Private Hospital prostheses charge	Total Private Hospital prostheses charge if public sector costs applied	Cost difference private vs public
A12Z	Insertion of Neurostimulator Device	2,438	$23,003	358	$16,079	$56,080,119	$39,200,792	43.1%
C16Z	Lens Procedures	65,234	$521	65,883	$274	$33,959,516	$17,892,446	89.8%
D01Z	Cochlear Implant	816	$22,309	634	$21,156	$18,203,785	$17,263,206	5.4%
F01A	Implantation or Replacement of AICD, Total System W Catastrophic CC	323	$58,419	727	$18,732	$18,869,224	$6,050,429	211.9%
F01B	Implantation or Replacement of AICD, Total System W/O Catastrophic CC	2,126	$54,310	2,316	$14,299	$115,462,656	$30,399,323	279.8%
F12B	Implantation or Replacement of Pacemaker, Total System W/O Catastrophic CC	6,282	$13,654	5,665	$4,261	$85,776,187	$26,770,513	220.4%
F15B	Interventional Coronary Procs, Not Adm for AMI W Stent Implant W/O Cat/Sev CC	8,925	$4,933	5,483	$1,931	$44,024,972	$17,233,451	155.5%
F17Z	Insertion or Replacement of Pacemaker Generator	2,047	$11,985	1,728	$3,520	$24,534,093	$7,205,954	240.5%
G10B	Hernia Procedures W/O CC	34,928	$550	27,903	$304	$19,218,433	$10,630,657	80.8%
I01B	Bilateral and Multiple Major Joint Proc of Lower Limb W/O Revision W/O Cat CC	2,261	$16,583	563	$11,700	$37,494,321	$26,454,202	41.7%
I03B	Hip Replacement W/O Catastrophic CC	19,224	$10,496	11,138	$6,341	$201,771,259	$121,892,775	65.5%
I04A	Knee Replacement W Catastrophic or Severe CC	4,866	$8,278	3,734	$6,460	$40,279,629	$31,432,811	28.1%
I04B	Knee Replacement W/O Catastrophic or Severe CC	23,527	$8,045	10,512	$6,412	$189,273,303	$150,848,901	25.5%
I05B	Other Joint Replacement W/O Catastrophic or Severe CC	3,013	$9,760	1,270	$6,811	$29,407,121	$20,521,379	43.3%
I06Z	Spinal Fusion for Deformity	817	$30,665	537	$20,982	$25,053,477	$17,142,542	46.1%
I09A	Spinal Fusion W Catastrophic CC	965	$22,047	771	$12,235	$21,275,471	$11,806,851	80.2%
I09B	Spinal Fusion W/O Catastrophic CC	8,691	$15,245	2,280	$9,180	$132,490,123	$79,786,235	66.1%
I13B	Humerus, Tibia, Fibula and Ankle Procedures W/O CC, Age >=17	12,735	$1,464	11,919	$1,085	$18,640,474	$13,812,159	35.0%
I16Z	Other Shoulder Procedures	34,048	$986	6,953	$776	$33,587,331	$26,426,872	27.1%
K11B	Major Laparoscopic Bariatric Procedures W/O CC	7,559	$3,580	485	$1,385	$27,064,470	$10,470,557	158.5%
	Total	240,825		160,859		$1,172,465,966	$683,242,056	71.6%*

PHDB = Private Hospital Data Bureau (Department of Health) http://www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-PHDBAnnualReportsArchived

NHCDC = National Hospital Cost Data Collection (Independent Hospital Pricing Authority) https://www.ihpa.gov.au/publications/australian-public-hospitals-cost-report-2013-2014-round-18 - document NHCDC Round 18 Cost Report Appendix

*If the public sector prostheses cost applied over all prostheses benefits paid by health funds, and the 71.6% difference is removed, prostheses payments would reduce by 41.3%.

Attachment B: Benefit growth with and without public sector prostheses cost parity, and effect on Australian Government Private Health Insurance Rebate

Benefit growth with and without public sector prostheses cost parity, and effect on Australian Government Private Health Insurance Rebate							
	Year	Total prostheses benefits paid by health funds*	Total Hospital Table Benefits** paid by health funds	Hospital Table Benefits if parity with public sector prostheses cost (41.3% reduction in prostheses costs**)	Percent reduction in hospital table benefits paid by health funds	Australian Government Private Health Insurance Rebate (under 65 yrs)***	Savings to Australian Government Private Health Insurance Rebate (under 65 yrs)
	2007-8	$1,236,100,501	$8,730,909,948				
	2008-9	$1,270,536,754	$8,969,393,378				
	2009-10	$1,379,957,264	$9,681,571,749				
	2010-11	$1,483,372,836	$10,580,621,141				
	2011-12	$1,569,973,649	$11,308,730,723				
	2013-14	$1,739,120,669	$12,321,695,982	$11,603,439,146	5.83%	30.00%	$215,477,051
	2014-15	$1,894,511,157	$13,236,645,632	$12,454,212,525	5.91%	29.04%	$227,218,574
	2015-16	$1,995,977,258	$13,860,610,563	$13,036,271,956	5.95%	27.82%	$229,331,001
Average growth		7.09%	6.83%				

* Based on the previous PHIAC A data and its successor APRA collection http://www.apra.gov.au/PHI/Publications/Pages/Private-Health-Insurance-Membership-and-Benefits.aspx. Note: tab "selection" enables quarterly data over recent years to be accessed.

**Based on 2013-14 data, a 41.3% reduction in prostheses benefits is projected if the private sector charges reflected public sector costs.

***For simplicity, the average tax rebate for those under 65 is used.

Attachment C: Projected prostheses benefits over the next three years with and without public sector cost parity

Projected Prostheses benefits			
Year	Projected cost of Prostheses benefits	If public price parity*	Difference
2016-17	$2,137,393,174	$1,254,649,793	$882,743,381
2017-18	$2,288,828,473	$1,343,542,314	$945,286,159
2018-19	$2,450,993,034	$1,438,732,911	$1,012,260,123
* based on 2013-14 data, a 41.3% reduction in prostheses benefits is projected if the private sector charges reflected public sector costs.			

Attachment D: hirmaa snapshot comparison of Australia and France prostheses pricing.

hirmaa snapshot comparison of Australia and France prostheses pricing.

29 October, 2015.

	Australia[1]	**France**[2]	**% Difference**
Pacemakers	Code: BT110 Name: Biotronik Australia Pty Ltd – Evia SR-T Price: $5,928.00	Code: 3414506 Name: BIOTRONIK, EVIA SR-T. 2947,63€ (AUD$4564.56)^	29.87
	Code: SJ194 and SJ207 Name: St Jude Medical Australia Pty Ltd - Anthem PM3112 CRT Pacemaker AND Anthem RF PM3212 Price: $13,520.0	Code: 3449002 Name: Stimulateur cardiaque triple chambre, St Jude, ANTHEM - pour les modèles suivants : PM3112 et RF PM3212. Price: 4000.00€ (AUD$6194.20)^	118.26
	Code: BS216 Name: Boston Scientific Australia Pty Ltd INVIVE LV-1 Cardiac Resynchronization Therapy Pacemaker Price: $12,480.0	Code: 3424781 Name: BOSTON SCIENTIFIC SAS (BOSTON) Stimulateur cardiaque triple chambre, Boston, INVIVE CRT-P. Price: 4000.00€ (AUD$6194.20)^	101.47
	Code: MI012 Naem: Medtronic Australasia Pty Ltd Consulta CRT-P Model C3TR01 Price: $13,520	Code: 3402041 Name: MEDTRONIC, Consulta CRT-P pour le modèle suivant : C3TR01. Price: 4000.00€	118.26

1. Australia current prostheses list – Department of Health http://www.health.gov.au/internet/main/publishing.nsf/content/prostheses-list-pdf-cp.htm/$file/ProsthesisListPart%20A.pdf
2. LISTE DES PRODUITS ET PRESTATIONS REMBOURSABLES - Maj Du 16.10.2015 - List of goods and services (LPP) effective 16/10/2015 L'Assurance Maladie http://www.ameli.fr/fileadmin/user_upload/documents/LPP.pdf

^ Exchange rate valid as at 28.10.2015; AUD $1 = €0.646

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		(AUD$6194.20)^	
femoral heads - HIP	Code: Name: Johnson & Johnson Medical Pty Ltd Pinnacle Femoral Head CoCr metal on metal Price: $2400	Code: 3112314 Name: Hanche, tête et tête à jupe alliage métallique, DEPUY, PINNACLE ULTAMET Price: 363.82€ (AUD$563.51)^	325.9
	Code: ZI735 Name: Zimmer Pty Ltd Head - Metal (Zimmer, Metasul) - Price: $2400.00	Code: 3112314 Name: Société Zimmer France (Zimmer) - Hanche, tête et tête à jupe alliage métallique, ZIMMER, METASUL. Price: 363.82€ (AUD$563.51)^	325.9

6,282 procedures requiring a pacemaker took place in private hospitals in 2013-14.[3] On average, each procedure cost $20,344, of which $13,801 was spent on prostheses devices. That's $86,697,882 spent on pacemaker devices in one year.

hirmaa's research shows that the minimum benefit for a St Jude pacemaker Australia is $13,520, whereas in France it is as low as 4000.00€ or AUD$6194. This is a 118 per cent difference in price.

Meanwhile, 20,251 hip replacements took place in Australia during 2013-14.[4] The average cost for all prostheses utilized in hip replacement procedures is about $10,000 per separation – equaling an annual bill of about $200 million.

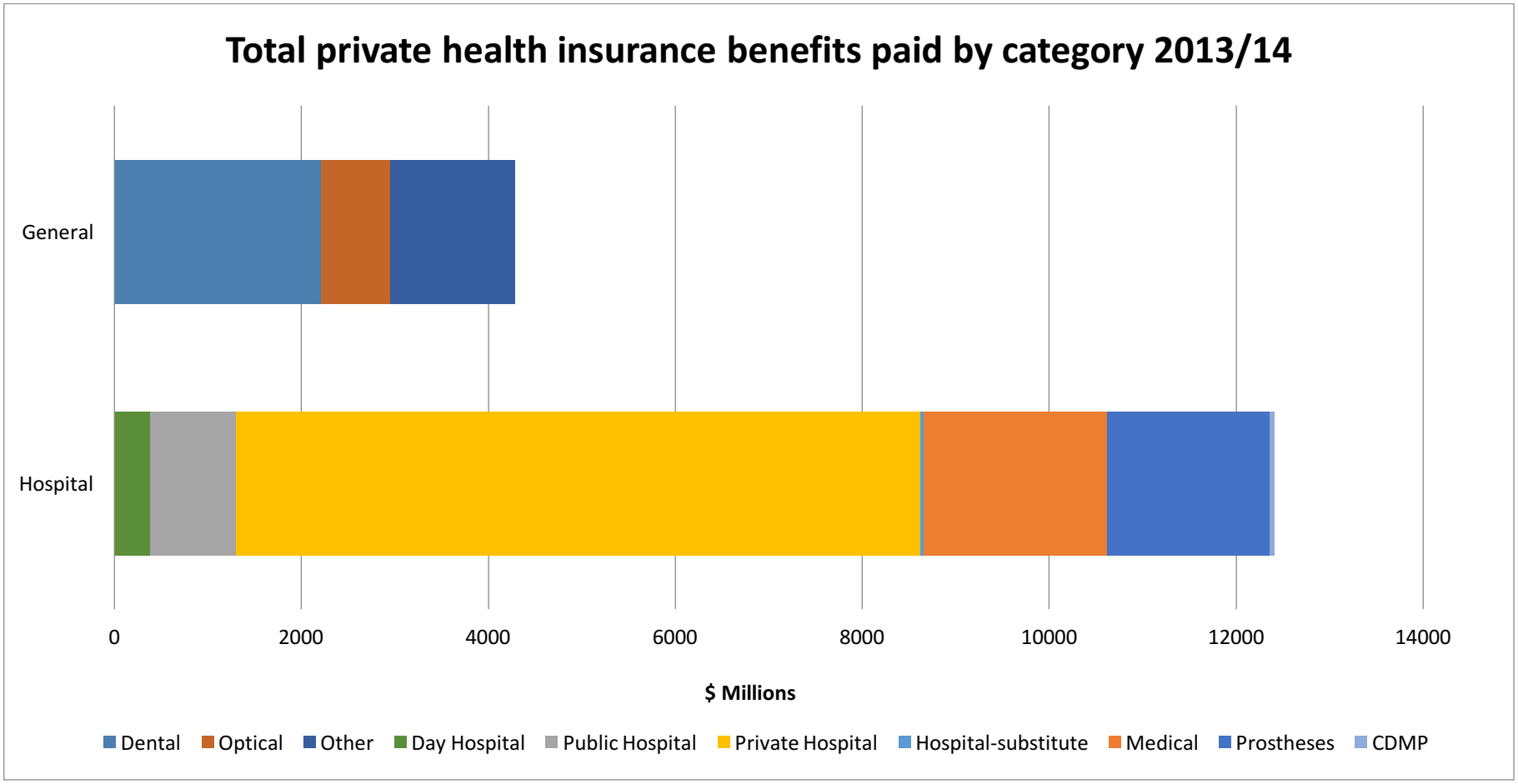
Within that massive expense to the Australian health system, however, hirmaa data shows that the standard price for a metal femoral head (part of the hip-joint mechanism) alone is far more expensive in Australia than in France.

A metal-on-metal Johnson and Johnson Femoral head costs Australian health $2400 per unit, representing a 325 per cent premium on French prices for the exact same product.

3. Private Hospital Data Bureau (PHDB) Annual Report 2013/14 http://www.health.gov.au/internet/main/publishing.nsf/Content/7F195B6C1A2801C6CA257BF0001F3ED4/$File/PHDB%20Annual%20Report%201314.xlsx
4. Ibid

^ Exchange rate valid as at 28.10.2015; AUD $1 = €0.646

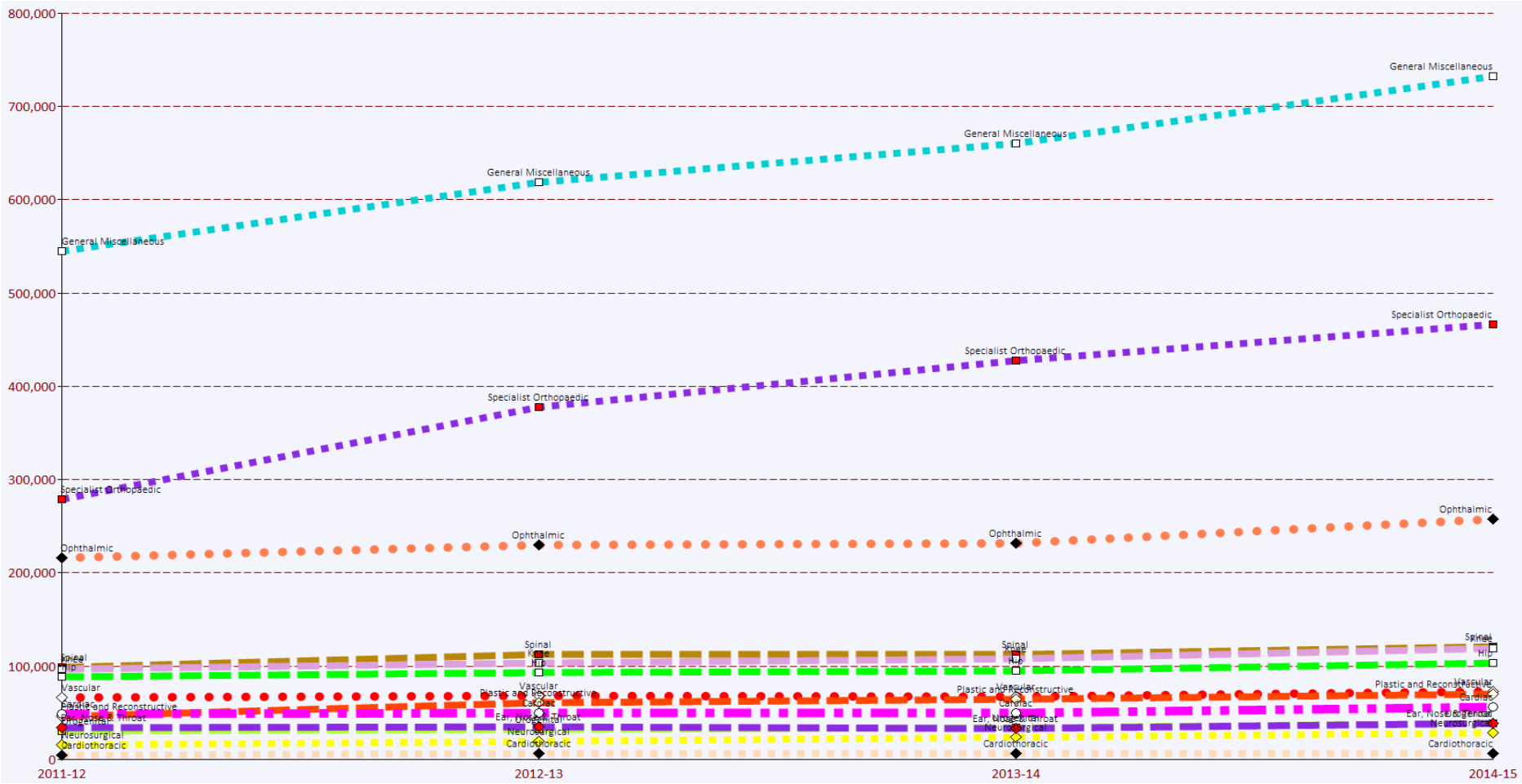
Attachment E: Total private health insurance benefits paid my category 2013/14



The total benefits paid by insurers in 2013-14 is $16.69 billion

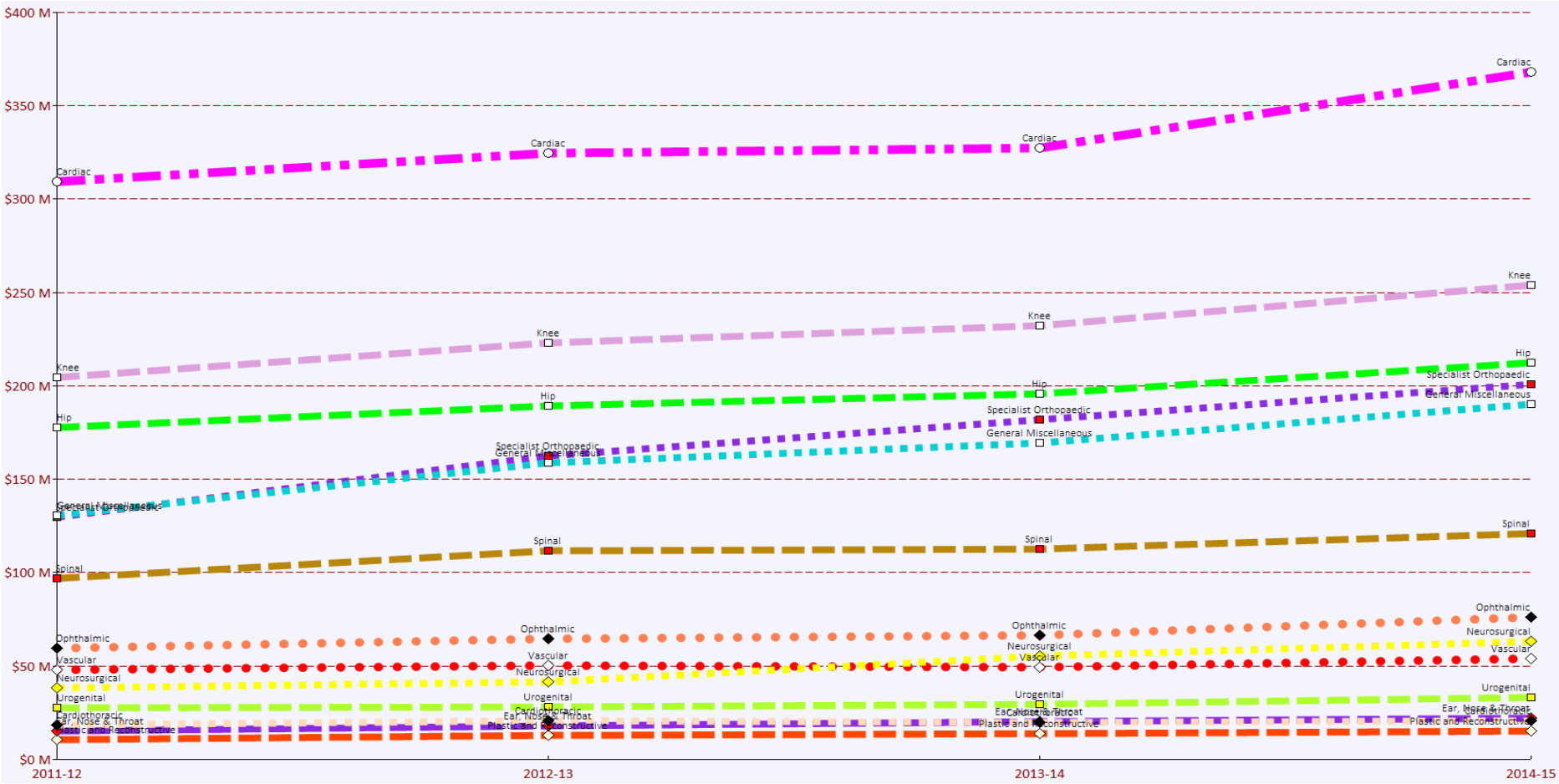
Source: Department of Health industry presentation to hirmaa General Meeting 9 March 2016.

Attachment F: Prostheses utilisation by category, 2011-12 – 2014-15



Source: Department of Health industry presentation to hirmaa General Meeting 9 March 2016.

Attachment G: Prostheses expenditure by category, 2011-12 – 2014-15



Source: Department of Health industry presentation to hirmaa General Meeting 9 March 2016.