ATTACHMENT

the schedule. In addition the Fund must pay an absolute minimum default benefit of $160 for admission to a day surgery. If one of the treating doctors has a financial interest in the day surgery there are even more potential perverse financial incentives imposed by regulation.

To make matters worse doctors (and hospital operators) are aware of the different "gap" payments and other benefits offered by different health funds. If the doctor wishes they can encourage a patient to transfer from a fund which pays a lower gap benefit to one which pays a higher gap benefit, virtually on the day of the procedure!

Portability entitlements were never intended to allow providers of care to arbitrage.

Portability

In 1988 the Parliament passed legislation, at the request of AHIA, to provide for portability of benefit entitlement to allow contributors to transfer between funds without the imposition of new waiting periods. This was intended to ensure that contributors with chronic conditions or pre existing ailments were not "locked in" to a particular fund but were as free as healthier members to transfer without renewed waiting periods. However up-grading of coverage was not permitted to occur, either within a fund or between funds, without serving a waiting period for higher levels of cover. This was intended to ensure that contributors could not take out low cost cover until about to receive treatment and then upgrade strategically. It was a measure aimed at protecting long term members of the particular higher cost product from "hit and run" activity.

At the time this was introduced contributors had a specific dollar entitlement depending on the product on which they were enrolled, and this specific entitlement was the maximum that could be paid for the first 12 months after transfer between funds. For example, if Fund A paid $300 per day for treatment in a particular hospital and Fund B paid $350 per day, a person transferring to Fund B would only be entitled to a benefit of $300 per day for their first 12 months membership with Fund B. Conversely if a member paid from Fund B to Fund A they would only receive the new Fund's (lower) benefit of $300 per day.

This arrangement was relatively easy to understand and transparent, for the benefit amounts were spelt out in brochure and other material relating to the product.

In 1995, however, the Parliament legislated to encourage hospitals and funds to enter into negotiated contracts with the aim of eliminating out of pocket expenses (other than those for which the patient had opted via excesses, co payments etc when choosing their level of cover). Contract amounts varied extensively and were based on a range of items including facilities, quality measures, provision of services etc. This, plus commercial confidentiality, blurred the visibility of the actual amount a fund paid to any particular hospital. In addition funds did not always have contracts with the same hospitals. However, for administrative convenience, funds usually accepted a transferee who had served out waiting periods with another fund without extensive checks to establish whether the former fund had the same contractual relationships.

Until recently portability of benefit entitlement was not an issue. However in 2003-04 the hospital group *Healthscope* entered into a contract dispute with a major health fund in South Australia based on the level of benefits *Healthscope* demanded for several hospitals in that State. During the dispute *Healthscope* encouraged members of the health fund to transfer to

other funds although, in fact, the health fund in dispute had made extensive arrangements to ensure pre-booked and other classes of patients remained covered. The application of portability rules required the receiving health funds to accept very significant and unexpected increases in their own benefit liabilities. Subsequently, the Managing Director of *Healthscope* claimed portability had been an essential ingredient in his group's strategy to force the original health fund to pay higher benefits.

The current situation is both unstable and inflationary. It means that providers of care, whether hospitals, doctors or others, can organise for patients to transfer from one fund to another at the point of treatment based on the benefit arrangements the provider has with various funds: i.e., encouraging transfers based on which fund pays the provider the most for their services (without consideration of other services the fund may provide). This constructive upgrading of cover by providers was never intended to be part of portability arrangements, and creates unfair imposts on longer serving members of a receiving fund. It should be remembered that in many cases smaller funds may, for a variety of reasons, pay higher benefits to some providers than larger funds. This would make them an attractive target for such selective upgrading by providers, but if it occurred on a large scale could result in the fund's prudential situation being threatened. In the case referred to above, AHIA understands the transfers which were so encouraged led to increases in liabilities of the receiving funds of more than $10 million in a very short period (even though the original fund had guaranteed payment for pre-booked patients). This shift is totally unfair to the longer term members of the receiving funds, whose own contributions have to be used to cover an influx of patients and is not much different from the "hit and run" situation. The sudden increase in liabilities could have bankrupted a small health fund.

AHIA has endeavoured to resolve this situation in an amicable way with the Australian Private Hospitals Association (APHA) and the Catholic health sector. At this stage we have reached agreement on various conditions that should apply in respect of a cessation of contract to ensure that pre-booked patients, those in courses of treatment and emergency situations are not disadvantaged. In general these arrangements provide for a run-on of fund benefits and acceptance of these benefits in full by the hospital. As a result such patients would not be out-of-pocket as a result of a cessation. The Private Health Insurance Ombudsman has been advised of these arrangements and has adopted them as his own protocols to be applied in a dispute.

Unfortunately, the hospitals have been less willing to agree to any arrangement which would prevent them encouraging transfers of members to maximise the benefits paid to them. As a result the AHIA Executive has now agreed that the best solution to this situation is ***to allow/or require health funds and hospitals to come to agreements about the charges and benefits to be paid in respect of members in the first 12 months after transfer from one fund to another. In effect hospitals would be required to apply agreed charges (corresponding to benefits) for such members for that period which may differ from those applying to longer standing members.***

This arrangement is intended to ensure that contributors' rights of transfer are not impeded, that any members who do transfer will be fully covered (other than product specific copayments, excesses etc), but discourage deliberate encouragement of transfers at point of treatment.

Although it would involve (presumably) a lesser charge/benefit to be paid to hospitals. In practical terms this arrangement is unlikely to have much impact on hospitals - unless they specifically plan to encourage large scale selective transfers as a negotiating tactic. The fact is very few members transfer between health funds each year, and even fewer who are undergoing or expect to undergo treatment. The number of patients who individual hospitals would admit under these arrangements would be very small.

Hospitals will argue this represents a "different benefit entitlement" for patients. However, different benefit entitlements already apply between and for patients. Contract benefits provided by health funds vary, sometimes significantly, between hospitals and within a hospital. Different payments are made for patients undergoing different treatments. Unless we return to the days of a specific published dollar figure per bed day, the principle of differential payments is already embedded in the system.

This arrangement does, however, take the problem of hospital-fund disputes back into the commercial area - where it should always have been, while ensuring a member's right to transfer from one fund to another without penalty is seamless. Patients could no longer become the pawns used to politicise a contract dispute.

If this proposal is unacceptable ***AHIA suggests that the Government adopt the necessary measures to restore the original concept of portability being a dollar entitlement. Under this proposal, provided a fund gives adequate notice of cessation of a contract, a transferring member's entitlements should be the dollar amount which their former Fund provided to a particular hospital on the day of transfer. Thus if a member transferred after a contract ceased the member would only be entitled to the former fund's own default benefit arrangements for the first 12 months with a new fund. Members who transfer before a contract expires would, for the first 12 months of membership, only be entitled to the former contracted benefits provided by the original fund up to cessation of the contract. To overcome commercial confidentiality an external party - the Department or Ombudsman - could ascertain benefits which would have applied based on MBS item or some other objective measure.***

Hospitals would be required to accept these benefits in full payment (other than co payments required in the policy) as a condition of receiving a provider number. This would ensure the member was not financially disadvantaged by transfers. Given that very few members transfer between funds in normal circumstances, and even fewer do so when planning hospitalization, this would have virtually no impact on hospital incomes. It would, however, discourage hospitals from attempting to use portability to arbitrage. It would also protect contributors from a sudden increase in their fund's liabilities (and premiums) due to a sudden influx of transferring members.

Providers Use Insurance to Subsidise Uninsured Patients

AHIA analysed the 30 most commonly performed Diagnostic Related Groups (DRG's) performed in private hospitals. These 30 DRG's represent 42% of all procedures performed in private hospitals in 2002-03. The analysis shows in 22 of the top 30 classifications private health insurers are charged more for the same procedure than a self insured patient. The relativity between the numbers of procedures performed by the insured/self insured is high – 16% of all procedures are for self insured patients. This indicates the cost structures should be