Australian
Private Hospitals
Association

Submission to the Consultation on Private Health Insurance Reforms – Second Wave Certification

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Certification – a private hospital sector perspective

Summary

Ensuring consumers receive clinically appropriate care and have certainty regarding out-of-pocket costs and what services their policy will cover should be the fundamental driver of reform.

Problems in regards to certification impact consumers in three ways:

- Rejection of certificates, sometimes after lengthy delays, can result in consumers receiving a debt from the hospital.
- The administrative burden on hospitals arising from certification requirements and the manner in which they are implemented by insurers diverts resources away from patient care.
- These pressures can leave some service providers with no option other than to require payment in advance from consumers who must then seek benefits from insurers.

Reforming requirements for hospital treatment certification has the potential to ensure a better experience for consumers as well as reduce administrative burdens on hospitals and insurers when implemented in an evidence-based manner.

There are three broad areas of concern to private hospitals, each of which require a different approach:

1. The regulatory burden arising from the way in which requirements for certification of Type C medical (or non-procedural) admissions has led to some insurers imposing excessive administrative requirements on private hospitals and beyond the Government's regulatory intent.
2. Certification of Type C non-medical admissions (i.e. procedural) and Type B admissions – an area which is raised in the consultation paper but which requires further research before an appropriate reform proposal can be framed.
3. Non-regulatory certification practices which, like regulatory requirements, impose a significant administrative burden on private hospitals and pose risks for consumers, which could be addressed through industry-wide collaboration and support from government.

As well as regulatory reform, once the scope and scale of the issue has been identified, additional resources provided to medical practitioners to assist in writing certificates and addressing inconsistencies in what health insurers will accept on certificates, should be priorities. There are some past industry initiatives that could inform an effective response but the Australian Government also has an essential role to play in this.

Background

The Australian Private Hospitals Association (APHA) welcomes the examination of measures to improve the process of disputation of "hospital certification" (Type B and Type C certificates) in order to ensure that such disputes are resolved in a timely and clinically appropriate manner. Despite the Department of Health PHI 17/37 circular of July 2017, Type C certification requirements are still challenging for both providers and private health insurers. Therefore, reform is in the interests of all stakeholders, and is the obligation of providers and insurers to ensure consumers are able to access care that is clinically appropriate for them and for which they are insured. The cornerstone of clinical autonomy must remain, and it is vital that this process does not undermine the clinical decision making of physicians.

APHA is concerned this consultation has been undertaken without a complete understanding of the size and scope of the issue at hand. APHA proposes a couple of ways in which the scope of the issue needs to be researched before appropriate reforms and other measures can be identified:

- Systematic research is required to ascertain the extent to which certificates are rejected and benefits either denied or delayed.
- The Department of Health (the Department) could also usefully inform the issue by undertaking analysis of the way in Type C Medicare Benefits Schedule (MBS) items are used in hospitals:
    - Analysis of PHDB/HCP data would reveal the circumstances in which these items are used, e.g. the diagnoses most prevalent in medical (non-procedural) admissions for which only a consultation item is charged and which specialties are charging them
    - Analysis of MBS claims would also allow the Department to better understand the extent to which some of these MBS items are claimed in hospital versus the community.

APHA would be pleased to work with the Department in undertaking this project.

Clarifying the extent and manner to which some items are used could guide a rational and proportional approach to both regulatory and non-regulatory solutions.

The implications for hospitals and consumers are significant. The resource implications of reforms options also need to be considered in order to ensure they are effective and sustainable.

Some APHA members have experienced a significant burden of disputes, despite the information provided by the Department that the issue is small, with minimal impacts. Furthermore, our members have experienced a growing number of disputed certificates for medical admissions (discussed below). Protracted disputes result in the need to collect payments from a patient many months after treatment, which adds greater administrative burden and will often create stress for the patient.

As same day separations account for an increasing proportion of the services provided by private hospitals and provide alternatives to high-cost overnight patient care, this issue will become more and more important. In 2018-19, private hospitals provided 3,351,265 same day separations, accounting for 72 percent of all separations in private hospitals, compared to just 60 percent in 2010-11[1*]. Care provided as a same-day separation is likely to continue to increase as medical technologies continue to advance.

Type C certificates for hospital admission and Type B certificates for overnight admission of the patient must meet the criteria outlined in the *Private Health Insurance (Benefit Requirements) Rule 2011*[2]:

> *(a) because of the medical condition of the patient specified in the certificate; or*
>
> *(b) because of the special circumstances specified in the certificate,*
>
> *it would be contrary to accepted medical practice to provide the procedure to the patient unless ….*

Legitimate rejection of certificates by health insurers occurs when the certification provided by the medical practitioner has insufficient detail to satisfy the insurers the criteria in the Private Health Insurance Rules have been met.

However, disputes frequently occur when health insurers reject certification on the basis they regard the reasons provided by the treating clinician as too generic or clinically unjustified. Health insurer representatives can differ in their interpretation. Some insurers automatically reject certificates on set criteria in the first instance and only settle claims when this rejection is appealed by the hospital. The perception that there is widespread fraudulent activity on the part of doctors or private hospitals in the certification process is false. There are however, widespread inconsistencies as to what health insurers will accept on a certificate.

Type C Certification of medical admissions

While Type C Rules include MBS items used in medical (non-procedural) admissions it has long been the practice of health insurers to waive this requirement and instead rely on other information, including coded data provided with the claim, to distinguish those episodes which require verification through the certificate process. Long standing

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[1] PHDB Annual Report 2019-20. https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-PHDBAnnualReports. Accessed 31 January 2021.
* Data excludes day hospitals.
[2] https://www.legislation.gov.au/Details/F2017C00555

conventions and historical understandings have enabled hospitals and health insurers to fulfil the intent and spirit of regulatory requirements without imposing on hospitals and doctors an unsustainable regulatory burden.

It has been of grave concern that some insurers have chosen to exploit a literal interpretation of the Rules to their financial advantage by demanding certification and causing protracted delays even in circumstances that were never the subject of disputation before. It is particularly disturbing this issue appears to have arisen in some parts of the sector, following the introduction of the 'First Wave' of private health insurance reforms which was explicitly intended to provide clarity and reassurance to consumers regarding the coverage provided by private health insurance products.

Each year the private sector provides 1,447,547 medical admissions[3]. The recent clarification by the Department (Friday 29 January 2021) that in their view, Type C certification is required for all medical admissions, is a development that threatens to bring this issue to a crisis point.

Some insurers have also taken a literal interpretation of Type C certification to mean the service provided has to be something other than the reason for admission. This interpretation leads to an insoluble and unintended paradox as illustrated in the following example:

> A patient comes into hospital with pneumonia and all that is being provided is the treatment for pneumonia. Consequently, there is nothing that can be added to the certificate that is not already stated in the reason for admission.

This problem is particularly prevalent in hospitals receiving unplanned medical admissions and patients admitted through emergency departments[4].

Certification requirements absorb significant private hospital resources in:

- Internal administration of claims processes to ensure all certificates are completed and filed which each claim, a process that is made even more inefficient when insurers insist on paper claims and will not accept electronic certificates.
- Appealing claim rejections, obtaining additional information from clinical records and from treating clinicians.
- Chasing out-of-pocket costs from consumers when insurers deny cover for treatments already provided.
- Providing information to medical practitioners regarding certification requirements.

[3] The Australian Institute of Health and Welfare (AIHW). Australian hospital statistics 2018–19: Admitted patient care. Chapter 5: What services were provided? https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients. Accessed 2 February 2021.

[4] There are more than 30 private hospitals in Australia with emergency departments.

In addition, private hospitals and day surgeries carry the financial burden of outstanding claims when resolution is delayed unduly by insurers. In some instances, claims may even lapse due to contractual requirements for settlement within a specified time.

So large has this issue become, that a growing number of private hospitals and day surgeries will be forced into the position of charging consumers up front for admissions and requiring them to seek retrospective reimbursement from their health insurer.

Although the consultation paper focuses on certification requirements mandated by regulation, there are wide range of additional certification criteria required for individual health insurers. These certification requirements are prone to the same problems as those associated with regulatory requirements:

- Significant administrative burden.
- Financial cost and risk to private hospitals.
- Out-of-pocket risk to consumers.

Historically some of these processes have been supported by industry guidelines (e.g. the Rehabilitation Certificate) but these have not been universally adopted and industry attempts to provide education and guidance have not been sufficient to address the problems outlined in this paper.

In addition to resolving regulatory issues, the APHA recommends the Department attend to measures that alleviate the considerable administrative burden associated with regulatory requirements and to encourage all parties to adopt the use of contemporary technologies and business practices to facilitate administrative efficiency and ensure quality service to consumers. These include:

- Provision within ECLIPSE for the processing of electronic certificates.
- Pending resolution of reform issues, endorsement of standardised industry certificate formats.

Comments in response to consultation questions

Proposed policy part one: Establishment of a self-regulating industry panel to manage disputes

1. **Should an industry mediation panel be established to resolve hospital certification disputes?**

Dispute management processes must be responsive and must also enable systemic reform so issues can be addressed in a timely and coherent manner. It is unclear if an industry panel has the potential to assist in resolving certification disputes, and there are important considerations in the establishment of such a body. Without a direct understanding of the number of the certification disputes likely to be mediated by a panel, there is no ability to assign resources to ensure it is sustainable or effective. If policy reform is not achieved in other areas contributing to issues with certification, a panel managing disputes would be overwhelmed.

The consultation paper provides the National Procedure Banding Committee (NPBC) as an example of a self-regulating industry body; however, this references only the existence of an industry body rather than any precedent of a mediation body successfully operating in this space. The Terms of Reference for the NPBC (under review) clearly outline the role of the NPBC as an advisory committee in aspects of the procedure banding mechanism only, rather than a designated dispute mediation body.

2. **If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?**

The above example of the NPBC is not an appropriate model for a clinical decision making panel. NPBC membership is comprised of private hospital and health insurance fund representatives. Given the basis of hospital certification is clinical, and any decision to admit a patient overnight is a clinical decision in its entirety, any such panel should be comprised of independent clinical experts. It is not clear how private hospital or insurance representatives could be included in this panel, whilst maintaining its focus on reviewing clinical decisions.

Where a mediating panel could be useful is for providing an escalation point to identify inconsistencies in what health insurers accept for certification on an aggregate level. That is, where clusters of disputes arise, the panel should release advice, endorsed by the Department, on how these disputes should be handled. The panel could also identify areas where disputes arise that may be amenable to the development of advice or recommendations by the relevant medical groups (see below).

Proposed policy reform part two: Encouraging the development of clinical guidelines for Type C procedures requiring hospitalisation by medical colleges.

Self-regulation initiatives in the private health sector are not a new concept. There have been numerous previous attempts such as:

- In 2001, APHA and the Australian Health Insurance Association established a voluntary code of practice (the HPPA Code) for hospital purchaser/provider agreement negotiations between private hospitals and private health insurers[5]. The code included an independent dispute resolution process through the Private Health Insurance Ombudsman.

- 'The Criteria for Type C Banding Certification: a guide for medical practitioners', which was produced by the Australian Medical Association, Australian Society of Plastic Surgeons and the Australasian College of Dermatologists in response to problems that arose in the wake of the MBS skin procedures review[6].

- The Consultative Committee on Private Rehabilitation: this committee, comprised of representation from private hospitals and private health insurers, has over many years maintained and revised industry guidelines and produced an industry standard certificate for rehabilitation[7].

- The Private Mental Health Alliance (which dissolved in 2016) produced and maintained industry guidelines for mental health[8].

However, as with many self-regulating initiatives, failure to adopt and recognise guidelines/codes by all parties and particular areas of disagreement are likely to remain and therefore government endorsement will be required.

[5] Voluntary code of practice for hospital purchaser/provider agreement negotiations between private hospitals and private health insurers. https://www.privatehealthcareaustralia.org.au/wp-content/uploads/codebookletFeb2001.pdf

[6] Criteria for Type C Banding Certification: A Guide for Medical Practitioners. Endorsed by the Australian Society of Plastic Surgeons, the Australasian College of Dermatologists, General Surgeons Australia and the Australian Medical Association; June 2018. https://www.dermcoll.edu.au/wp-content/uploads/Criteria-for-Type-C-Banding-Certification-ASPS-ACD-GSA-AMA-June-2018-FINAL.pdf

[7] Guidelines for Recognition of Private Hospital-Based Rehabilitation, August 2016 Services.http://www.apha.org.au/resource/guidelines-for-recognition-of-private-hospital-based-rehabilitation-services-march-2015/ and Rehabilitation Certificate Template https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Rehabilitation-Program-Certificate-template-effective-1-August-2015.pdf

[8] Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care 2015 Edition https://nla.gov.au/nla.obj-299533756/view

3. **What parties should be involved in the development of advice on the appropriate criteria for certification?**

Whilst it would seem reasonable for medical colleges to develop statements/policies to provide insights on appropriate criteria for certification in those areas where disputes arise, there would need to be adequate resources provided to the colleges as well as consultation and time allowance for organisations such as APHA and other stakeholders to give feedback. Guidelines developed to this end must be endorsed by the medical colleges and the Department itself, and enforced by any mediation body, should one be established.

4. **Should there be a specified list of 'special circumstances' allowable for Type C certificates?**

A non-exclusive list may be of some assistance, however, a specified list of allowable circumstances cannot possibly comprehensibly cover all the complex circumstances in which a Type C certificate may be needed. Guidelines should not supersede the clinical autonomy of medical practitioners and should not be used by insurers as a checklist to refuse claims regardless of their clinical appropriateness.

Proposed policy part three: Escalation of disputes or severe breaches to the Professional Services Review (PSR) for decision

5. **Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?**

The extension of the PSR for resolution of certification disputes is a major step and it is unclear in what circumstances or why such an escalation is necessary. Furthermore, this proposal would require expansion of the PSR authority and expertise. Quantification of the issue and a deeper understanding of the scope of potential breaches is required before such a substantial change to the PSR should be considered.

More ubiquitous are unfounded hospital certification rejections by health insurers. There is nothing in the proposal to hold insurers accountable for unreasonable conduct, such as rejection on spurious grounds, unnecessary delays or excessive auditing practices.

Any escalation mechanism should include in its scope capacity to refer health funds for persistent and arbitrary rejection of certificates, with enforceable outcomes.

6. **Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?**

For Type C certificates, it is the admitting doctor, not the hospital, who provides certification for an overnight admission. There are also regulatory provisions for Type B certificates, to allow a professional who is employed by the hospital in the provision of that service to sign a certificate in some circumstances.

Other Questions:

7. What is the likely impact upon premiums of this proposal?

A positive impact on administrative overheads should ensure an increased percentage of premiums will be spent on the provision of health services and a corresponding reduction in the upwards pressure of premiums.

8. What is the likely impact on the number of people and/or policies covered of this proposal?

No comment.

9. What are appropriate metrics for measuring the impact of this proposal?

Metrics should be designed once the reform proposal is further developed.

The net impact must include a reduction in administrative burden for private hospitals and medical practitioners.

An appropriate metric would be a reduction in certification disputes, but more research is needed to discover what the baseline level of disputes currently is.

10. What is the regulatory burden associated with this proposal?

The regulatory burden of this proposal cannot be determined without further work to scope the issue and redesign the proposal to ensure that is provides a proportionate and appropriate response to the issues identified.

It is the APHA's view that reforms are necessary to reduce an unsustainable regulatory burden of current certification requirements.

11. Are there any other reform options that should be considered?

As aforementioned, without significant further research to gain comprehensive knowledge of the size and scope of the issue at hand, there is no ability to fully understand the resourcing required or the regulatory burden associated with these proposals. APHA strongly encourages the Department to conduct further consultation and research into hospital certification before attempting to reform the process.

Private hospitals in Australia

The private hospital sector makes a significant contribution to health care in Australia, providing a large number of services and taking the pressure off the already stretched public hospital system.

The private hospital sector treats:

- 4.43 million hospitalisations a year.

In 2016–17 it delivered:

- 60 percent of all surgery
- 73 percent of eye procedures
- Almost half of all heart procedures
- 73 percent of procedures on the brain, spine and nerves.

Australian private hospitals by the numbers:

- Almost half (49 percent of all Australian hospitals are private
- 657 private hospitals made up of:
    - 300 overnight hospitals
    - 357 day hospitals
- That amounts to: 34,339 beds and chairs (31,029 in overnight hospitals and 3,310 in free-standing day surgeries)
- Employs more than 69,000 full-time equivalent staff[i9].

The Australian Private Hospitals Association

The Australian Private Hospitals Association (APHA) is the peak industry body representing the private hospital and day surgery sector. About 70 percent of overnight hospitals and half of all day surgeries in Australia are APHA members.

[9] Australian Institute of Health and Welfare 2018. Admitted patient care 2016–17: Australian hospital statistics. Health services series no. 84. Cat. no. HSE 201. Canberra: AIHW. https://www.aihw.gov.au/getmedia/acee86da-d98e-4286-85a4-52840836706f/aihw-hse-201.pdf.aspx?inline=true Accessed 18 February 2019.