REPORT:

MINISTERIAL ADVISORY COMMITTEE

ON OUT-OF-POCKET COSTS

November 2018

Executive Summary

Out-of-pocket medical costs have become an increasing concern for consumers and the private health industry.

Out-of-pocket costs are the difference between the fee charged for a health treatment or service, and the combined Medicare and private health insurance benefits for the service. It is the amount the patient is personally "out-of-pocket".

Consumers can be faced with large and/or unexpected costs; this can cause financial hardship and contribute to a perception that private health insurance provides poor value for money.

In October 2017, the Minister for Health, the Hon Greg Hunt MP, announced that an expert committee would be formed to provide advice on out-of-pocket costs. This was part of a wide ranging package of reforms to make private health insurance simpler and more affordable for Australians. Link to reforms webpage:
http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reform

The Committee, chaired by the Commonwealth Chief Medical Officer, Professor Brendan Murphy, was asked to provide advice on best practice models to make information on out-of-pocket costs charged by medical specialists more transparent, to help consumers understand out-of-pocket costs and to inform consumer choice. Link to Committee webpage:
http://www.health.gov.au/internet/main/publishing.nsf/Content/min-advisory-comm-out-of-pocket

The Committee met five times and also worked out-of-session to develop practical options.

The Committee accepts that out-of-pocket costs have, for a long time, been charged by some medical specialists for services provided either in a hospital or in the community. Historically, out-of-pocket costs have generally been proportionate and adjusted to the financial circumstances of the consumer. It is apparent that, more recently, a minority of medical specialists have been charging very large fees, including to patients on low incomes. The Committee expressed serious concerns about such egregious charging and noted also the cumulative financial impact of more modest charges. The Committee further expressed strong concerns about the practice, by an unknown number of medical specialists, of charging 'hidden' administrative or booking fees, which are not disclosed to Medicare or private health insurers and circumvent the requirements of the 'no' or 'known' gap private health insurance arrangements. The Committee was of the view that all charges from a given provider, for an admitted clinical episode, should be provided on a single bill.

The Committee noted that informed financial consent has been strongly promoted by the medical colleges and the Australian Medical Association (AMA) and is done well by many medical specialists. The process of informed financial consent, however, occurs after the first consultation. By this time many patients feel locked into the clinical relationship and reluctant to extricate themselves to obtain another opinion and fee.

The Committee was strongly of the view that patients need better fee information before this first consultation, noting that such information is complex and has limitations when provided outside of a formal clinical consultation.

The Committee concluded that the best options to aid patients and their General Practitioners (GPs) when choosing a medical specialist would include all or some of the following elements:

- a Government funded website with Government oversight that includes information about:
  - individual medical specialists' costs for most common services, searchable by medical specialist and with the data populated by specialists (see option 1a for more detail); and
  - the range of specialists costs for common services, searchable by specialty and geographic region, using data from existing Government sources, but noting that such data may be incomplete (see option 1b for more detail).
- education for consumers, GPs and medical specialists to improve understanding of out-of-pocket costs and aid in the referral process. In particular, a concerted education campaign is required to inform consumers that there is not necessarily any relationship between fees charged and the quality of medical care.

The Committee noted the significant issues with ensuring participation by all medical specialists with the website disclosure and explored a range of options to achieve such participation during a transition period.

Terms of Reference and Core Principles

The Terms of Reference (at Attachment A) stated that the role of the Committee was to provide advice on possible reforms covering:

- best practice models for the transparency of in-hospital medical out-of-pocket costs, and associated medical services in the community;
- legislation and regulatory barriers to consumer transparency of out-of-pocket medical costs;
- the implementation of best practice models; and
- other related issues as directed by the Minister.

Committee membership is at Attachment B.

The Committee met five times on: 8 February; 23 March; 20 June; 24 August; and 19 October 2018.

During the development of transparency options, the following general principles were considered by the Committee:

- any changes made must benefit the consumer;
- consumers must be presented with clear, concise and up-to-date information that is accessible and as easy to understand as possible, given the complexity of the information being provided;
- risks of any interventions must be identified and fully explored to help prevent unintended consequences from occurring e.g. publication of median fees in a region may cause lower charging medical specialists to increase fees;
- the importance of consumer choice in selection of medical specialists, from amongst a GP recommended list;

- it is important that transparency and other approaches adopted be achieved by a general agreement of medical specialist leaders, the private health insurance industry and consumers;
- the work being undertaken by the Committee will complement the broader private health insurance reforms; and
- the practice of charging 'hidden', booking or administrative fees is unacceptable and the options must seek to eliminate this practice.

What are out-of-pocket medical costs?

In Australia, if a patient is admitted to a public hospital as a public patient, generally the patient is not charged for any hospital or medical services.

If the patient chooses to be treated as a private patient, in a public or private hospital, each of the medical specialists may charge a fee. These fees are in addition to the fees the hospital may charge. The difference between the specialist's fee and the combined Medicare and private health insurance benefits is paid by the patient "out-of-pocket". The drivers of out-of-pocket costs are complex and multifactorial. These include a perception by a number of medical specialists regarding the adequacy and complexity of Medicare and private health insurance reimbursements. Details of patient funding flows are at Attachment C.

In addition to admitted services, medical out-of-pocket costs are incurred by patients when fees charged for non-admitted consultations or procedures are greater than the Medicare benefits for those services. Medicare data demonstrates that in General Practice the great majority of services are bulk billed (no out-of-pocket costs) but, for other specialties, consultation fees commonly involve an out-of-pocket cost. Pathology services are generally bulk billed as are some simple radiology services. The largest total non-admitted out-of-pocket costs are seen in a number of specific areas, such as management of pregnancy, assisted reproductive services, radiation oncology and intra-ocular injections. The large total out-of-pocket costs may be related to the high number of services provided in the relevant treatment area (e.g. intra-ocular injections), or because of the very high out-of-pocket costs charged for a treatment area (e.g. management of pregnancy), or a combination of both high service numbers and cost (e.g. radiation oncology).

Non-admitted costs are not covered by private health insurance but attempts have been made to address these costs by the introduction of the Medicare Safety Nets (original and extended). While the increased Medicare payments from the safety nets have provided some relief for patients, they have also arguably had an inflationary effect on fees charged. Capping of some safety net items has also had an impact on the net out-of-pocket costs for patients.

The Committee has only considered non-GP specialist out-of-pocket costs. There is scope to expand the proposed solution to GPs in the future. For the purposes of this paper, the term medical specialist refers to non-GP specialists. The Committee also did not consider non-medical out-of-pocket costs, such as pharmaceutical fees, hospital charges and dressings; it is accepted that these can be significant in some instances.

Background – the extent of out-of-pocket medical costs

In 2015, the Department of Health (the department) conducted a consumer survey on private health insurance. Over 40,000 responses were received. The survey found consumers were concerned about being left with large out-of-pocket costs and not knowing what those costs would be. The Consumers Health Forum also initiated a survey on out-of-pocket costs in April 2018 which attracted 1,200 responses. Some of the findings were:

- more than a quarter of respondents treated for breast cancer incurred an out-of-pocket cost of more than $10,000;
- one in six respondents said that out-of-pocket costs had a significant impact on their lives;
- a third of respondents said the out-of-pocket costs were not explained to them before treatment; and
- there was a common view that using private health insurance would expose people to more costs.

Out-of-pocket costs feature regularly in the media and in May 2018 Four Corners featured an episode on out-of-pockets costs. This program requested that viewers send in their medical bills detailing their out-of-pocket costs and several hundred were received. The program exposed individual egregious billing practices, the cumulative costs to cancer patients undergoing treatment over a long period of time and the cumulative costs to patients with chronic disease having long term ambulatory care with private medical specialists.

Consumers are well-aware of out-of-pocket costs and this may be a contributing factor to the decrease in private health insurance participation rates.

The Australian Prudential Regulation Authority (APRA) released the September 2018 quarterly data which shows that private health insurance participation rates continue to decline. In the past 13 consecutive quarters hospital treatment coverage has declined in proportional terms and in the September 2018 quarter has declined to 44.9 per cent compared to 45.8 per cent in the same quarter in 2017.

Private hospitals report a significant drop in the number of bookings for childbirth, with some private maternity services closing in recent years. The out-of-pocket cost for management of a pregnancy in the private system has been clearly associated with the decision of many people (who have private insurance) to elect to have their pregnancy managed in the public hospital system.

The Minister regularly receives correspondence from patients with complaints of large out-of-pocket costs. Below are some examples of the out-of-pocket costs incurred by patients:

- upfront gap of $5,000 before hip replacement surgery was performed;
- $1,000 for monthly chemotherapy appointments for multiple tumours in leg;
- surgery for breast cancer $5,000, pathology $3,000;
- $5,000 for radiation treatment as an outpatient;
- $4,088 for a hip replacement (pensioner over 80 years of age);
- $820 for a tooth extraction (anaesthetic, filling tooth cavity and stitch, extraction, consultation) for pensioner; and
- arthroscopic procedure on knee $1,975 (surgeon only).

The department's Hospital Casemix Protocol Annual Report (2016-17) shows that 64.4 per cent of separations have no gap and 88.2 per cent of services had no gap. This means that 35.6 per cent of patients are experiencing out-of-pocket costs which vary from a few hundred dollars to tens of thousands of dollars (see data table at Attachment D). This is, however, likely to be an underestimate of the proportion of patients experiencing out-of-pocket costs as some patients will have been charged additional booking or administrative fees.

There is also evidence of financial hardship caused by medical out-of-pocket costs. A number of patients have reported the need to take out a loan or an additional mortgage and others have made special applications for early access to superannuation.

Current Situation – information about out-of-pocket costs

Private health insurers and other organisations/individuals have developed comparison tools/websites for consumers to be able to research potential out-of-pocket costs for medical procedures prior to the first consultation, for example Medibank's comparison tool (https://www.medibank.com.au/livebetter/what-is-the-cost-of-my-procedure/), the healthshare website (https://www.healthshare.com.au/) and the BUPA website (https://www.bupa.com.au/health-insurance/surgery-cost-calculator). While these websites give an indication of what the out-of-pocket cost may be, not all factors are considered in these calculations, for example variables such as the medical specialist, how complicated the surgery is and private health insurance coverage. These websites also do not have a complete data set, and hidden or booking fees are not captured.

Committee Consideration

The Committee discussed the following options to address the lack of transparency of out-of-pocket costs:

- Option 1a: Individual Practitioner Fee Information – Medical Specialists' own data on Current Fees;
- Option 1b: Aggregated Out-of-Pocket Costs Data – Government Historical Data; and
- Option 2: Individual Practitioner Fee Information – Government Historical Data.

For all options, the Committee agreed there should be an out-of-pocket costs campaign to promote the website and educate consumers and health care professionals about out-of-pocket costs.

Option 1a: Individual Practitioner Fee Information – Medical Specialists' own data on Current Fees

This option would involve a website showing the fees charged and 'most common' out-of-pocket cost information for participating medical specialists, covering the major Medicare Benefits Schedule (MBS) services they provide. The Committee agreed that it would be too complex to cover all possible fees charged by a medical specialist. The Committee agreed that the data should be limited to MBS items related to outpatient consultations as well as the top 80 per cent by volume of the other MBS items provided by that medical specialist. The data would be populated and kept current by medical specialists using an online portal. Medical specialists would commit to charges consistent with their declared fee schedule, with the potential for consumer law consequences for deviation. This would cover both in-hospital and out-of-hospital treatment. Medical specialists would further commit on

the website that they will not charge hidden booking or administrative fees and that all fees would be associated with a clinical service.

The department engaged Oban Consulting to interview Committee members and other medical leaders across various medical specialties to determine what type of information would be appropriate to display on a potential website for both doctors and consumers. After several discussions and iterations of the template, the Committee recommends the following information be included in the template:

> **Medical Specialist Details:** This section would include the name of the medical specialist; specialty; address; website; and details of consulting rooms and hospitals.
>
> **Approach to Fees:** This section would allow doctors to specify if they use 'no' or 'known' gap arrangements. This would determine if they need to populate their detailed fee information in the table. Medical specialists would also be allowed to populate additional information in a free text box. For example, medical specialists may wish to explain their charging practices for concessional patients, or the circumstances when they do or do not use 'no' or 'known' gap arrangements. This section would also include a statement that commits medical specialists to not charge booking fees. For example: *"the medical specialist will not charge administrative fees, booking fees or issue split invoices for a single clinical service".*
>
> **Fee Information Tables:** The fee information table would be pre-populated with: MBS items for consultations and those that make up 80 per cent of the volume of Medicare services provided for each medical specialist; a simple descriptor for each MBS item; and the MBS fee where required. Medical specialists would populate their maximum fee and most common out-of-pocket cost for each MBS item and confirm them on at least an annual basis (or earlier if they wish to change their fees).
>
> **Health Team:** This section would require the medical specialist to identify their health team by populating a table with the names of other medical specialists or providers they most commonly work with in procedures, for example: anaesthetists, assistant surgeons. This would then link to these medical specialists' or other providers' individual web page and their fees.

The department worked with some members of the Committee and other medical specialists to populate templates as examples of the information that would be provided on an individual provider page on a website (completed templates at Attachment E). The Committee considers that these templates provide a good basis for further consultation and development during any website implementation.

Templates were tested by a small number of consumers. Consumers were asked a number of questions about the templates and the following feedback was received:

- suggest better defining 'no' and 'known' gap arrangements;
- focussing on MBS item numbers can be confusing for the consumer;
- it would be helpful to have examples of common procedures and list the MBS items involved;

- make it clear that the website only includes medical out-of-pocket costs, not hospital (e.g. accommodation, excess);
- having two prices (normal and concessional) could be confusing;
- non-admitted information is more readily understood than admitted information;
- patients would like to be able to enter their private health insurance information and get a personalised response;
- the information may not be specific enough for individual cases. Some consumers may find this misleading; and
- data on the most common out-of-pocket cost is of limited value.

Further modifications were made after the consumer feedback was received and considered, and is incorporated in the templates at Attachment E.

Following feedback from anaesthetists the Committee considered that the proposed template, which requires fee and cost data for individual MBS items, is unlikely to be an effective way to convey anaesthetist out-of-pocket costs. Anaesthetists' fees are based on a unit system that reflects the complexity of the service and the time the service took. If a transparency website was adopted, further development would be required for the instructions, explanation text and to include anaesthetists' fees by reference to a combination of MBS items for common procedures rather than fees for individual MBS items. If a fee transparency website were progressed, formal consumer testing would need to be conducted and strong consumer involvement maintained throughout the development process.

Implementation of such a website could take at least one year and up to two years. This would include time for development of detailed requirements (including public consultation), tender and assessment, building and testing (including formal consumer and medical specialist testing), and release for an initial population period. Early indicative estimates of the cost to externally develop and host this website are $6.5 million over four years for the development and roll-out, including $930,000/year for software licences and help desk support.

The significant challenge of achieving full participation in this website by medical specialists is discussed later under risks and sensitivities.

Option 1b: Aggregated Out-of-Pocket Costs Data – Government Historical Data

This option would involve a website (or part of the option 1a website) that would show the range of out-of-pocket costs for each MBS item for the most recently available 12 month period. This would be aggregated across all medical specialists, potentially in each State/Territory, not identified by individual medical specialist. Data would be extracted from existing datasets (e.g. MBS and Hospital Casemix Protocol). Again, the data would be incomplete in that it would not include hidden booking or administrative fees charged to patients in that period.

Consumers would see the fees and range of out-of-pocket costs charged by MBS item, and would be able to compare this with the fee information on the medical specialist's website entry (or information otherwise provided directly to the patient by the medical specialist).

Accordingly, these data would complement the individual medical specialist information provided in option 1a.

Information could be included about MBS items often grouped together in the provision of a significant number of popular procedures so as to increase the usefulness and ease of use of this option. This would require work to agree on procedures for this to be applied to, and which items to include. This would be a complex piece of work, requiring significant time and resources.

Indicative cost for a Government developed and managed website is approximately $350,000 over four years (year 1 - $255,000 and $25,000 per year ongoing). If the website was developed and managed externally, the estimates cost is approximately $1.5 million over four years (year 1 - $715,000 and $260,000 per year ongoing). Based on discussions with Departmental officers, the Committee understands that the time to release could be less than a year.

Examples of the type of information that could be viewed for option 1b are at Attachment F.

The department's usual practice is that, before data can be released to the public, all data that may allow a person to be identified must be suppressed. Consequently, for any combination of individual MBS item and geographic level (e.g. state/territory, SA4, SA3, SA2 etc.), data on out-of-pocket costs for medical services for admitted patients in hospitals may not be released publicly if there are small numbers of service providers or services.

The initial analysis in the table in Attachment G indicates a large proportion of MBS items may need to be suppressed if reporting at the state/territory level occurred. This may limit the value of data reporting at the state and territory level rather than at the national level.

As with some other published data, some data could be consolidated to help overcome this issue. For example, include ACT in NSW, and include NT in SA, noting however that this may diminish the usefulness of the information for consumers in smaller states or territories.

The Committee agreed that this option would not be of use as a standalone website if a large amount of data needed to be suppressed due to the potential to identify a person (e.g. the health care provider). However this option would complement option 1a because the range of charges made in the geographic area could be used for comparison with individual practitioner fees and costs.

Option 2: Individual Practitioner Fee Information – Government Historical Data (not recommended)

This option would involve a website showing historical fee information covering the MBS items for consultations and those that make up 80 per cent of the volume of Medicare services provided by each medical specialist in the most recently available 12 month period. Information would be extracted from existing datasets (e.g. MBS and Hospital Casemix Protocol) and identify individual out-of-pocket costs where possible. Medical specialists could be asked to commit to not exceed these historical fees by more than an agreed percentage, but this would be likely to attract significant concerns from medical specialists. Medical specialists would need to consent to the release of

individual data where it was available. Currently individual doctor out-of-pocket data is only available in Government datasets for out-of-hospital treatment

Where individual data is not currently available legislative or administrative arrangements would need to be changed to collect that data. Private health insurers collect, and could be asked or required to provide to the Commonwealth, individual medical specialist out-of-pocket costs for hospital treatment. This would need full voluntary compliance with agreement from all parties on use for out-of-pocket transparency, or it would need to be legislated. Historical data on admitted treatment costs would be less useful for this purpose in that it excludes hidden booking and administrative fees that have not been disclosed to Medicare or the private health insurers.

Implementation of this website would likely be slightly shorter than option 1a with the development cost being comparable to option 1a. This option responds to the key objective of providing transparency before the first appointment, and does not rely on medical specialist completion. Despite initially being seen as the simplest option, the Committee decided not to further consider this option, due to the issues around data completeness and data access.

Out-of-Pocket Costs Education Campaign

Part A: education

In addition to a fee information website model, the Committee agreed the importance of education, in particular education around the referral process, and getting the message to consumers that higher medical fees do not necessarily have a relationship to higher quality care. The Committee also acknowledged the role for GPs in the solution to transparency and supporting patient choice.

Education should focus on:

- *consumers* – to encourage use of the website, consideration of value when choosing a medical specialist, and to correct any misapprehension that the size of medical fees has a relationship to the quality of care provided;
- *GPs* – to encourage them to discuss costs as one factor when referring patients to medical specialists and to encourage the offering to patients of a number of acceptable medical specialists, to enable the patient to make a choice; and
- *medical specialists* – ensuring specialists understand how their billing approaches impact out-of-pocket costs.

There is a common misconception that referrals need to be addressed to a specific medical specialist. This is not the case. Referrals may be 'open' but the Committee took the view that GPs would generally prefer to provide an open referral only to a limited list of recommended medical specialists.

Part B – website promotion

The Committee agrees that for a fee information website model to work, the Government, medical profession, insurers and consumer representatives would need to collaboratively develop and promote this reform. An introductory front page of the website would need to provide information about out-of-pocket costs and how they arise (for example to ensure a strong understanding of the role of Medicare, insurers, preferred providers, no and known gaps). Detailed market research would be needed to develop targeted messaging.

Consumer Complaints

The Committee also considered whether implementation of a fee transparency solution and education campaign may lead to increased complaints about high out-of-pocket costs. Members discussed whether it would be helpful to identify a mechanism to deal with complaints about high out-of-pocket costs. However, it was considered that there are currently several mechanisms for complaints, including under consumer law, health complaints commission arrangements, and the Medical Board of Australia. The Department will consult further with the relevant complaints bodies.

Issues, Risks and Sensitivities

The following issues, risks and sensitivities have been identified across the options:

Data quality

All options would have risks around completeness and accuracy of data (e.g. using multiple data sources; fees for service or other booking/administration fees not captured in Government data, variance in data completion under the doctor populated model, different costs for the same MBS item due to the Multiple Operation Rule may result in an over or under estimation in cost for an individual).

These limitations have led the Committee to conclude that best way to display fee information is for the medical specialist to provide their current fees (option 1).

Individual Practitioner Current Fees: Option 1a relies on medical specialists (or their practice staff) accurately recording their fees in a template. Medical specialists would be able to update their template on the website at any time and change their fees (increasing or decreasing fees). Some members of the Committee completed a template developed by the department and, across this small group, there were different interpretations of how to complete the template. Feedback from medical specialists who completed the templates suggests that the task would not be particularly burdensome if clear instructions were provided. However, under option 1a there is a risk that information may not be provided in a truly comparable manner. Education and ongoing support for specialists and their staff will be important to ensure their information is correctly captured through a web portal.

Government Historical Data: Options 1b and 2 rely on the use of the department's existing datasets which have risks around completeness and accuracy. Fees for service or other booking or administration fees not disclosed to Government datasets reduces the accuracy of the data, which would be particularly problematic if the website attempted to show data at the individual medical specialist level. The data could also be up to 18 months old. This would mean that fees included on the website may lag behind the current charging by medical specialists, and that the mix of MBS items available on the website would not be up to date.

Participation

There is a risk that only a small number of medical specialists would participate in an individually identified fee information website (option 1a). The Committee was strongly of the view that full or near full participation was essential with a fee disclosure solution. A transition period, during which

medical specialists would be encouraged to participate, would be required and could be as long as two years. Potential regulatory mechanisms (if an initial opt-in period does not result in high participation) were discussed, but the Committee agreed that it is likely that these would only be considered if all other measures had failed. There is considerable merit in a consumer education campaign (run potentially by government and private health insurers) with the message that consumers (and referring GPs) should only choose those medical specialists who are prepared to disclose their fees on the website. After a reasonable transition period the website could show, for those non-participating medical specialists, a statement, for example "All doctors were asked to share their fee information. This doctor has declined".

The medical colleges, AMA and private health insurers will be very important in assisting with participation.

Medical specialists increase fees

While transparency and consumer pressure may influence outlier providers to lower their costs due to increased consumer price sensitivity, there is a corresponding risk that some medical specialists might increase their fees when they see what their colleagues charge. In 2009, the then Medicare Australia commenced publishing Provider Percentile Charts on its website to show health professionals how their billing patterns compared to their peers. Research found that publication of most charts, each covering a select range of MBS items, coincided with an increase in average billing for the affected MBS items.

This risk could be mitigated by compiling doctor fee templates for a transition period before any publication, such that subsequent changes would be apparent. A consumer education campaign ("price is not necessarily quality") would also mitigate against this risk.

MBS item numbers, complexity and applicability for the individual

Information at the MBS item number level would be provided in the option 1 website. These are not intuitive for consumers and simplified descriptors would need to be provided. GPs would have an important role in explaining to patients what items are likely to be relevant to the upcoming medical specialist encounter.

Given the complexity of medical practice, the data provided in the medical specialist's fee template would need to have some disclaimers, while still being sufficient to compare medical specialists in relation to the costs of consultations and common/uncomplicated procedures.

No/known gap arrangements

'No' and 'known' gap arrangements are an important part of the private health insurance coverage for admitted services. Some medical specialists routinely use them when available, enabling much simpler information to be provided in relation to their fees. However, some medical specialists only use them in some circumstances (e.g. concessional patients) and the arrangements can vary amongst insurers. The fee template website would emphasise the need for consumers to confirm information with their private health insurer.

Prohibiting booking and administrative fees may increase out-of-pocket costs for some consumers

The 'no' and 'known' gap schemes operated by most private health insurers provide benefits greater than the 25 per cent of the MBS fee that they are required to cover. A 'known' gap is usually $500. The example below shows how a gap scheme may work.

EXAMPLE: For an admitted procedure, the 100 per cent MBS fee is $1,000 and the PHI agreed 'no' gap fee chargeable by the medical specialist could be limited to a maximum of $1,500. If this fee is charged, the Commonwealth pays 75 per cent of the MBS fee ($750) and the insurer pays 25 per cent of the MBS fee ($250) plus the remaining $500 under the 'no' gap arrangement. The patient has no out-of-pocket costs.

If the medical specialist exceeds the agreed 'no' gap fee, the insurer will only pay 25 per cent of the MBS fee. For example: the medical specialist instead charges $2,000 (above the agreed maximum), the Commonwealth pays 75 per cent of the MBS fee ($750), the insurer only pays 25 per cent of the MBS fee ($250) and the patient is out-of-pocket $1,000.

Some medical specialists are circumventing agreements with the insurer to charge only the 'no gap' amount by charging on one invoice the $1,500 (fully covered by the Commonwealth and the insurer) with the patient receiving a separate invoice for a 'booking fee' of $500. In this circumstance, the medical specialist receives the $2,000 and the patient's out-of-pocket cost is reduced to $500.

There is a risk that if the hidden fee practice is stopped, this may negatively impact patients as they may incur increased out-of-pocket costs. This would occur if the issue of a single account reduced the amount the private health insurer contributed to payment of the overall fee. Alternatively, the medical specialist could reduce his or her fee. Both outcomes could lead to savings to private health insurers that could be reinvested. For example: provide incentives for a higher 'no' or 'known' gap agreed fee for some expensive procedures or provide a reduction in premiums.

The department engaged Private Healthcare Australia to work with IPSOS to survey patients about out-of-pocket costs and in particular the prevalence of hidden fees/booking fees. At the time of writing this advice, the survey is not complete. Early responses confirm ongoing consumer concerns about out-of-pocket costs, particularly if they are not advised well in advance. They also indicate that booking and administration fees are charged in about 11% of hospital admissions and other 'hidden' fees in about 5% of admissions. This information will require careful consideration when a Report on the Survey is provided.

Which medical specialists should be included in the fee template website (option 1a)?

The Committee agreed that GPs should be excluded from the transparency solution initially. Including GPs in a website transparency solution would more than double the number of initial participants. The magnitude of out-of-pocket costs associated with some specialist services is much larger than for GPs, so the Committee considered that on balance it would be preferable to initially gain acceptance of the new transparency with specialists. Extending the solution to GPs could be considered later.

The Committee also agreed that all medical specialists who bill under a Medicare provider number should be included. This may involve some specialists who bill only a small number of events, but it was considered important to have full coverage. It was considered that new medical specialists could

be provided with a 12 month transition period before the website would indicate that they had chosen not to provide their fee information. New medical specialists may choose to publish their fees from the beginning, which would promote their approach to fees and costs.

The range of participants on the website would require review after an initial period. This could gauge the level of participation to gauge whether GPs could be added, and whether including all specialists regardless of MBS service volume, is appropriate.

Corporatised practices

Some private clinical services such as radiation oncology, assisted reproductive services and diagnostic pathology and radiology are delivered in a corporatised model where headline billing by one or more medical specialists occurs. There is no difference in the amount billed by the different providers in the practice. The Committee is of the view that in these situations an individual medical specialist fee template is of no value. Rather the corporate entity has a scale of fees applicable for services which usually applies at all places of business. Corporate entities would be asked to provide a fee scale on their website which could be linked from the main government fee transparency website.

Legislation

Depending on the preferred option, the *Privacy Act 1988* and the *Health Insurance Act 1973* or other legislation or regulations/rules may need to be amended. If mandating participation is considered, further advice would be needed on potential constitutional matters.

Preliminary consideration was given to potential consumer law issues, particularly around the proposed commitment by medical specialists not to charge above a certain amount, and not to charge booking or other hidden fees. Commonwealth, State and Territory consumer law would potentially provide the compliance mechanism if doctors charged differently to their commitment. The potential consumer law issues would need to be explored further during development of any commitments required to be made by providers on the website. Advice would be needed from the Australian Competition and Consumer Commission and potentially through State and Territory consumer bodies.

As discussed above, current laws and guidelines for release of Government-collected data may require suppression of some of the aggregated data about out-of-pocket costs because data aggregated to a useful geographic area may allow a person to be identified. Legislative amendments may be needed to ensure Option 1b could provide sufficiently useful information. Amendments could permit publication of out-of-pocket costs data aggregated to a reasonable geographic area, even if an individual health care provider could be identified by matching the data with other available information.

Committee Advice

While each option could be implemented individually, the Committee considers that options 1a, 1b and the out-of-pocket costs campaign should be adopted as a package of reforms to improve transparency around out-of-pocket costs. The Committee considered that the campaign would be an important part of any transparency solution.

The Committee agrees that for a website model to work the Government, medical profession, insurers and consumer representatives need to collaboratively develop and promote this reform. Careful research and development, and extensive consultation and testing would be required across the wider private health industry, consumers and website/marketing experts to ensure a robust website model was implemented and complemented by an effective education campaign.

The Committee recommends that, should Government decide to adopt this advice, a reference group be formed to provide advice during implementation.

Attachment A

Terms of Reference

Ministerial Advisory Committee on Out-of-Pocket Costs

Purpose

The government recognises that there is increasing community concern about out-of-pocket fees charged by a relatively small proportion of medical practitioners and the transparency of medical costs in advance of referral. In some instances these fees result in considerable patient out-of-pocket costs and financial hardship, and the fees charged do not have a clear relationship to the quality or nature of the medical services provided. These concerns are shared by many medical professional associations, the private health insurance industry and consumer groups. The government is keen to work with the medical profession to identify the drivers for these fees and costs and to explore strategies that may improve the provision of information for consumer choice, and the fee charging practices.

The Ministerial Advisory Committee on Out-of-Pocket Costs (the Committee) brings together key individuals with expertise in clinical practice, private health insurance, and consumer issues to work in partnership on the development of best practice models to make information on out-of-pocket costs charged by doctors more transparent and to help consumers with private health insurance better understand out-of-pocket costs.

On 13 October 2017, the Minister for Health, the Hon Greg Hunt MP announced a wide-ranging package of reforms including the establishment of an expert committee to consider options to improve the transparency of medical out-of-pocket costs.

Functions

The role of the Committee is to provide advice to the Minister on possible reforms covering:

- best practice models for the transparency of in-hospital medical out-of-pocket costs, and associated medical services in the community;
- legislation and regulatory barriers to consumer transparency of out-of-pocket medical costs;
- the implementation of best practice models; and
- other related issues as directed by the Minister.

It is expected that Committee members will draw on professional and other networks in considering options presented to the Committee.

To support these functions, members of the Committee will:

- act in a collegiate and collaborative manner when debating and resolving issues; and
- respect the confidentiality of Committee procedures.

External Support

The Committee may be supported through the commissioning of external advice (through the Department of Health), if required.

Membership

The Committee is chaired by Professor Brendan Murphy. Members are appointed for their knowledge, expertise and experience in clinical practice, private health insurance, and consumer issues.

With the Chair's prior approval, individuals and organisations who are not members may be invited to participate in the Committee discussions where they have particular knowledge, expertise, or experience.

A quorum for a meeting is the Chair and half the Committee membership plus one. A quorum of members must be present before a meeting can proceed. A member who is unable to attend a meeting should advise the Chair and the Secretariat as soon as possible.

Confidentiality

Members are required to sign confidentiality agreements, and to declare any real or potential conflicts of interests at the commencement of each meeting. All Committee members have an obligation to maintain confidentiality regarding all matters arising within the Committee, and to maintain this confidence even after their membership of the Committee has expired. Committee members are specifically obliged to refrain from making any comment or statement concerning any Committee matter to any member of the media. The Chair of the Committee or the Secretariat will coordinate all media contact.

Timing

The Committee will meet in person, or via teleconference. The Committee is expected to meet four times in 2017-18, and twice in 2018-19. The Committee can meet more or less frequently if required, and will provide advice to the Minister for Health.

Decisions and consideration of issues can be made out-of-session by the Committee, including by teleconference, or videoconference.

Secretariat

The Department of Health will provide secretariat support for the Chair and the Committee. Papers will be distributed to Committee members at least five working days before a Committee meeting, except with the Chair's agreement. The agenda for meetings will be agreed between the Chair of the Committee and the Secretariat.

Attachment B

Ministerial Advisory Committee on Out-of-Pocket Costs

MEMBERSHIP

Member	**Organisation represented**
Prof Brendan Murphy (Chair)	Department of Health
Mr John Batten	Royal Australasian College of Surgeons
Dr Andrew Miller	Australian Medical Association
Prof Steve Robson	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Prof David A Scott	Australian and New Zealand College of Anaesthetists
A/Prof Mark Daniell	Royal Australian and New Zealand College of Ophthalmologists
Dr Lawrie Malisano	Royal Australasian College of Surgeons
Prof Mark Frydenberg	Royal Australasian College of Surgeons
Prof Christian Gericke	Royal Australasian College of Physicians
Ms Cathy Ryan	Catholic Health Australia (St John of God Health Care)
Ms Jo Root	Consumers Health Forum
Mr Andrew Sando	Australian Health Service Alliance
Mr Rhod McKensey	nib
Dr Michael Coglin	Australia Private Hospitals Association
Dr Mark Sinclair	Australian Society of Anaesthetists

MEDICARE ELIGIBLE PATIENTS – TYPICAL PATIENT FLOWS AND FUNDING STREAMS

PATIENT SEES GENERAL PRACTITIONER (GP)

Patient is bulk-billed: GP receives 100% of MBS Schedule Fee for a non-referred attendance; GP is not allowed to charge out-of-pocket fee. This is the usual scenario.

OR

Doctor charges patient a doctor-determined fee. The Commonwealth contributes 100% of the MBS Schedule Fee for a non-referred attendance, and patient pays the remainder out-of-pocket.

Patient referred through Public Hospital Route

PATIENT SEES SPECIALIST– for this consultation, the patient is a non-admitted hospital patient.

Patient is a public patient and the hospital is responsible for the cost of the consultation. Both the State and Commonwealth (through the National Health Reform Agreement) contribute to the funding of this service. There is no charge to the patient. This is the traditional scenario.

OR

Patient is a private patient. These patients are almost always bulk-billed – the doctor receives 85% of the MBS Schedule Fee for a referred attendance; under their employment conditions (which vary greatly), the hospital charges the doctor a "facility fee" and the remaining MBS income is channelled back to the hospital or to something like a trust fund for clinical training. This is now becoming the more usual scenario.

PATIENT ADMITTED TO HOSPITAL AS A PUBLIC PATIENT

The hospital is responsible for the cost of the admission, including medical costs and hospital (accommodation) costs. Both the State and the Commonwealth (through the National Health Reform Agreement) contribute to the funding of this admission. There is no charge to the patient. This is both the traditional and typical scenario for a public patient.

PATIENT ADMITTED TO A PUBLIC HOSPITAL AS A PRIVATE PATIENT (generally only patients with private health insurance)

MEDICAL FEES

These patients are almost always charged the MBS Schedule Fee.
Commonwealth contributes 75% of the MBS Schedule Fee.

AND

Insurer is required to pay remaining 25% of the MBS Schedule Fee.

HOSPITAL (ACCOMMODATION) CHARGES

Insurers are required to pay the "minimum default benefit" to public hospitals. Hospitals almost always charge only the default benefit.
For "genuine" private elections, the patient may pay an excess on their private health insurance.
For "encouraged" private elections, hospitals usually waive the patient's private health insurance excess so that patients can be guaranteed no out-of-pocket costs if they elect to be private.
The cost of the service is higher than the minimum default benefit. The State and the Commonwealth (through the National Health Reform Agreement) pay the remainder of this cost.

Note

This schema shows the most common patient flows and funding streams for a Medicare-eligible patient. Not every theoretically possible scenario is included. The schema does not show the scenario when a procedure is done in the doctor's rooms, or when a patient presents directly to the Emergency Department of a hospital and is then admitted to the hospital.
The funding shown is for a patient not eligible for bulk-billing incentives or the Extended Medicare Safety Net.
Funding for pathology, diagnostic imaging and pharmaceuticals is not included.
Funding of prostheses for private patients is not separately identified; private health insurance generally covers 100% of prostheses charges for private patients in public or private hospitals.

Patient referred through Private Route

PATIENT SEES SPECIALIST– this is a consultation in the doctor's rooms.

Patient is bulk-billed: specialist receives 85% of MBS Schedule Fee for a referred attendance; specialist is not allowed to charge out-of-pocket fee. This is a very unusual scenario.

OR

Doctor charges patient a doctor-determined fee, Commonwealth contributes 85% of the MBS Schedule Fee for a referred attendance, and patient pays the remainder out-of-pocket. This is the usual scenario.

PATIENT ADMITTED TO A PRIVATE HOSPITAL

MEDICAL FEES

Patient receives 75% of the MBS Schedule Fee from the Commonwealth.

AND

Insurer is required to pay remaining 25% of the MBS Schedule Fee.

AND

In most cases, the doctor's charge is higher than the MBS Schedule Fee.
If the doctor uses the patient's insurer's "No Gap Arrangement", the insurer pays the doctor an agreed amount above the MBS Schedule Fee and the patient has no out-of-pocket cost.

OR

If the doctor uses the patient's insurer's "Known Gap Arrangement", the insurer pays the doctor an agreed amount above the MBS Schedule Fee and the patient pays the remainder of the agreed total charge as an out-of-pocket cost.

OR

If the doctor does not use a No Gap or Known Gap Arrangement, the doctor determines their charge and the patient pays the full amount above the MBS Schedule Fee as an out-of-pocket cost.

HOSPITAL (ACCOMMODATION) CHARGES

Almost all private patient admissions are covered under hospital-insurer contracts. The hospital charges the agreed amount for the admission.
If the patient has a private health insurance policy with an excess, they pay the policy excess amount to the hospital directly, and their insurer pays the remainder of the contracted amount. There is usually no additional out-of-pocket hospital cost except the excess.

OR

If the patient has a policy with no excess, the insurer pays the full contracted amount. There is usually no out-of-pocket hospital cost.

OR

If the admission is not covered under a hospital-insurer contract, the hospital will usually be eligible for "Second-Tier Default Benefits". The hospital can charge any amount.

If the patient has a private health insurance policy with an excess:
The patient pays the policy excess amount to the hospital directly.

AND

The insurer pays 85% of their average contracted rate for that service in like hospitals *less* the excess already paid by the patient.

AND

The patient pays the remainder of the hospital charge out-of-pocket.

OR

If the patient has a private health insurance policy with no excess:
The insurer pays 85% of their average contracted rate for that service in like hospitals.

AND

The patient pays the remainder of the hospital charge out-of-pocket.

Attachment D

Privately Insured Separations (with a medical component) – length of stay and average medical charges/benefits/gap, by hospital type, 2016-17

2016-17

Hospital type	Separations with medical component	Average Length of Stay (days)	Average medical charge per separation (with medical component) ($)	Average Medicare benefit paid per separation (with medical component) ($)	Average fund benefit paid per separation (with medical component) ($)	Proportion of separations (with medical component) with no medical gap (%)	Average medical gap payment across all separations (with medical component) ($)	Average gap payment (per separation (with medical component)) where gap was paid ($)
Public	460,050	4.8	$939	$599	$323	81.4	$17	$93
Private - day	528,213	1.0	$933	$431	$401	74.6	$101	$399
Private - overnight	2,312,142	2.8	$1,746	$809	$700	58.2	$236	$565
Private - total	2,840,355	2.5	$1,595	$739	$644	61.2	$211	$545
TOTAL	**3,300,405**	**2.8**	**$1,503**	**$720**	**$600**	**64.1**	**$184**	**$512**

Notes:
- Includes additional Medical data supplied by insurers in the HCP1 Episode Record only.
- Separations with medical component refers to separations with a medical charge and where either an insurer benefit was paid or no insurer benefit was paid but Medicare covered the entire medical costs.
- Records were excluded with invalid or missing charges/benefit amounts. Affects less than 1% of records.
- Excludes hospital (e.g. accommodation, theatre, prostheses etc.) charges and benefits
- Excludes records where the type of care was reported as Newborn (without qualified days), Posthumous organ procurement and Hospital boarder.
- Hospital type refers to the hospital type specified in the Department of Health's Declared Hospital Information Management database.

Source: Hospital Casemix Protocol Collection
Department of Health - June 2018.

Privately Insured Medical Services – average medical charges/benefits/gap, by hospital type, 2016-17

2016-17

Hospital type	No. of medical services	Average amount charged per service ($)	Average Medicare benefit paid per service ($)	Average fund benefit paid per service ($)	Proportion of services with no medical gap (%)	Average gap payment across all services ($)	Average gap payment (per service) where gap was paid ($)
Public	5,897,808	$69	$44	$24	96.2	$1	$33
Private - day	2,448,267	$201	$93	$86	88.8	$22	$194
Private - overnight	22,724,957	$178	$82	$71	85.9	$24	$170
Private - total	25,173,224	$180	$83	$73	86.1	$24	$172
TOTAL	**31,075,226**	**$159**	**$76**	**$63**	**88.0**	**$20**	**$163**

Notes:
- Records were excluded with invalid or missing charges/benefit amounts. Affects approx. 2% of records.
- Excludes records where the type of care was reported as Newborn (without qualified days), Post-humous organ procurement and Hospital boarder.
- Total includes services were hospital type could not be determined in Medical Record.
- Excludes hospital (e.g. accommodation, theatre, prostheses etc.) charges and benefits
- Excludes records where the type of care (as reported in the associated Episode Record) was reported as Newborn (without qualified days), Posthumous organ procurement and Hospital boarder
- Hospital type refers to the hospital type specified in the Department of Health's Declared Hospital Information Management database.
- The number of medical services is greater than the number of separations with a medical component as a separation can have one or more medical services (i.e. MBS items).

Source: Hospital Casemix Protocol Collection
Department of Health - June 2018.

Attachment E

EXAMPLE 1:

Medical Practitioner details

Name		
Specialty	Anaesthetist	
Suburb		
State		
Website URL		
Consulting Rooms Private	Location	
	Phone Number	

Approach to Fees – No Gap

I participate in 'no gap' arrangements with private health insurers for hospital services.*	☐ Yes, always, for all insurers [Instruction to specialist: no need to complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☐ No [Instruction to specialist: complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☒ Sometimes/Not always [Instructions to specialist: if 'no gap' is used sometimes, you should include an explanation in 'Additional information' box below, and complete the 'admitted' services table]

***For practitioners who participate in no gap schemes there will be no out-of-pocket costs (all of the fee is fully covered by Medicare and the Private Insurance Fund). There may be other fees, for example for members of the Health Team mentioned below.**

Approach to Fees – Known Gap

I participate in 'known gap' arrangements with private health insurers for hospital services.* 'Known gap' or other out-of-pocket cost information	☐ Yes, always, for all insurers ☐ No [Instruction to specialist: complete 'admitted' services table] ☐ Sometimes/Not always

is in the 'Admitted (in-hospital) Consultations and Procedures' table below.	[Instructions to specialist: if 'known gap' is used sometimes, you should include an explanation in

***For practitioners who participate in the known gap scheme for an MBS Item, there will be a capped maximum amount, which is commonly up to $500. HOWEVER, 'known gap' does not apply for some Private Health Insurance Funds and in some circumstances. To get accurate information for your particular case, it is important that patients contact their private health insurer to confirm your coverage and to confirm whether the fee will be fully covered. Health fund contact information can be found by clicking here**

Additional information about Fee charging practice

Dr xx fees will vary depending on individual patient's circumstances. The figures below are intended as a guide. More information can be obtained by contacting his consulting rooms or referring to his practice website (details above) especially if the procedure is not listed below.

Depending on the nature of your procedure, or other health-related issues, a pre-admission consultation with Dr xx may be necessary, and may have an associated cost. Again, contact the practice for details.

The practitioner will not charge administrative, booking fees or any fees not associated with a clinical service

Non-admitted (out-of-hospital) Consultations and Procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Most common out-of-pocket costs for Dr xx for this item*
17610			
17640			
20740	Anaesthesia for endoscopy (stomach)		$0
20806			
20810	Anaesthesia for colonoscopy		$0
20952	Anaesthesia for day-surgery gynaecology		
21922	Anaesthesia for radiology (CT-guided procedures, MRI)		
21926			
21941			
21942	Anaesthesia for cardiology procedures		$0

***If patients are eligible for Medicare Safety Net Payments, the Medicare benefit paid may be higher than 85% (and therefore the out-of-pocket cost reduced)**

Admitted (in-hospital) Consultations and Procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Most common out-of-pocket costs for Dr xx for this item*
20810	Anaesthesia for colonoscopy		$0
20740	Anaesthesia for endoscopy (stomach)		$0
22905	Anaesthesia for dental procedures		$250-500 (time dependent)
20952	Anaesthesia for day-surgery gynaecology		$100-175
21942	Anaesthesia for cardiology procedures		$0
21943	Anaesthesia for cardiology procedures		$0
20806	Anaesthesia for laparoscopic procedures (gynaecology, hernia repair, gall bladder)		$150-350
21922	Anaesthesia for radiology (CT-guided procedures, MRI)		$0
21940			
21926			
22031			
20911			
20846			
20914			
20790			

*** The benefits paid by insurers, and the amount of any 'known gap', is not the same for all Private Health Insurance Funds or in all circumstances. To get accurate information for your particular case, it is important that patients contact their private health insurer to confirm your coverage and to confirm whether the fee will be fully covered. Health fund contact information can be found by clicking here**

EXAMPLE 2:

Medical Practitioner details

Name		
Specialty	Urologist	
Suburb		
State		
Website URL		
Consulting Rooms Private	Location	
	Phone Number	
Consulting Rooms Public Hospital	Name	
	Location	
	Phone Number	
Hospital Public	Name	
	Location	
	Phone Number	
Hospital Private	Name	
	Location	
	Phone Number	

Approach to Fees – No Gap

I participate in 'no gap' arrangements with private health insurers for hospital services.*	☐ Yes, always, for all insurers [Instruction to specialist: no need to complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☐ No [Instruction to specialist: complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☒ Sometimes/Not always [Instructions to specialist: if 'no gap' is used sometimes, you should include an explanation in 'Additional information' box below, and complete the 'admitted' services table]

***For practitioners who participate in no gap schemes there will be no out-of-pocket costs (all of the fee is fully covered by Medicare and the Private Insurance Fund). There may be other fees, for example for members of the Health Team mentioned below.**

Approach to Fees – Known Gap

I participate in 'known gap' arrangements with private health insurers for hospital services.*	☐ Yes, always, for all insurers ☐ No [Instruction to specialist: complete 'admitted' services table] ☒ Sometimes/Not always [Instructions to specialist: if 'known gap' is used sometimes, you should include an explanation in 'Additional information' box below and complete the 'admitted' services table]
'Known gap' or other out-of-pocket cost information is in the 'Admitted (in-hospital) Consultations and Procedures' table below.	

***For practitioners who participate in the known gap scheme for an MBS Item, there will be a capped maximum amount, which is commonly up to $500. HOWEVER, 'known gap' does not apply for some Private Health Insurance Funds and in some circumstances. To get accurate information for your particular case, it is important that patients contact their private health insurer to confirm your coverage and to confirm whether the fee will be fully covered. Health fund contact information can be found by clicking here**

Additional information about Fee charging practice

Dr xx fees do exceed, in some circumstances, those recommended by the Australian Medical Association for more complex urological procedures. In some circumstances, Dr xx will reduce fees charged for consultations and procedures in recognition of a patient's financial circumstances. Please contact his consulting rooms for more information.

This practitioner undertakes to charge only fees associated with a clinical service and Medicare item number, except for the following clinical services that do not attract a Medicare Benefit.
High Intensity Focussed Ultrasound of the Prostate, Focal therapy of prostate, Rezum therapy prostate, Prostate aquablation
……
The practitioner will not charge administrative, booking fees or any fees not associated with a clinical service.

Non-admitted (out-of-hospital) Consultations and Procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Medicare Benefits Payable – 85% of Schedule Fee	Most common out-of-pocket costs for Dr xx for this item
104	Initial Consultation	$230	$73.85*	$164.85*

				(Concession $94.85)
105	Subsequent Consultation	$140	$37.15*	$107.25* (Concession $77.25)
55039			$32.20	
11900			$23.45	
36812			$141.70	

***If patients are eligible for Medicare Safety Net Payments, the Medicare benefit paid may be higher than 85% (and therefore the out-of-pocket cost reduced)**

Admitted (in-hospital) Consultations and Procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Most common out-of-pocket costs for Dr xx for this item*
37219	Prostate needle biopsy using prostatic ultrasound	$780.85	$500
55603	Ultrasound prostate, bladder base and urethra	$609.10	$500
36812	Cystoscopy with urethroscopy	$666.70	$500
37203	Transurethral resection prostate	$3542.15	$2500 (Concession $500)
37211	Radical prostatectomy with lymph node dissection	$6935.20	$5000 (Concession $500)
36845	Cystoscopy with resection/diathermy	$1691.40	$1000 (Concession $500)
36818	Cystoscopy with ureteric catheterisation	$776.60	$500

*** The benefits paid by insurers, and the amount of any 'known gap', is not the same for all Private Health Insurance Funds or in all circumstances. To get accurate information for your particular case, it is important that patients contact their private health insurer to confirm your coverage and to confirm whether the fee will be fully covered. Health fund contact information can be found by clicking here**

Health Team

There may be other medical fees associated with your procedure. Professor Frydenberg generally works with the following specialists. See individual specialist information on their webpage on this website, or follow link below to corporate websites.

Anaesthetists	1	
	2	
	3	
Surgical Assistants	1	
	2	

Other Consultants / Specialists	1	
Medical Imaging	1	
	2	
Pathology	1	
	2	

EXAMPLE 3:

Medical Practitioner details

Name		
Specialty	Dermatologist	
Suburb		
State		
Website URL		
Consulting Rooms Private	Location	
	Phone Number	

Approach to Fees

This practitioner undertakes to charge only fees associated with a clinical service and Medicare item number, except for the following clinical services that do not attract a Medicare Benefit

……

The practitioner will not charge administrative, booking fees or any fees not associated with a clinical service

Non-admitted (out-of-hospital) Consultations and Procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Medicare Benefits Payable – 85% of Schedule Fee*	Most common out-of-pocket costs for Dr xx for this item*
104	Initial Consultation	$234/$167 (concession)	$73.85	$157
105	Subsequent Consultation	$138/$107 (concession)	$37.15	$99
14050	PUVA or UVB therapy	$75	$44.85	$30
30071	Diagnostic biopsy of skin	$178/$78.20 (concession)	$44.40	$134
30192	Treatment of premalignant skin lesions	$91.00/59.35	$33.65	$26
30196	Confirmed malignant neoplasm of skin	$290/187.80 (concession)	$107.40	$183
31361	Removal of malignant skin lesion	$510/$307.55 (concession)	$158.70	$351

*The Medicare benefit paid may be increased (and therefore the out-of-pocket cost reduced) if patients are eligible for Medicare Safety Net Payments

EXAMPLE 4:

Medical Practitioner details

Name		
Specialty	Ophthalmologist	
Suburb		
State		
Website URL		
Consulting Rooms Private	Location	
	Phone Number	

Approach to Fees – No Gap

I participate in 'no gap' arrangements with private health insurers for hospital services.*	☐ Yes, always, for all insurers [Instruction to specialist: no need to complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☐ No [Instruction to specialist: complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☒ Sometimes/Not always [Instructions to specialist: if 'no gap' is used sometimes, you should include an explanation in 'Additional information' box below, and complete the 'admitted' services table]

***For practitioners who participate in no gap schemes there will be no out-of-pocket costs (all of the fee is fully covered by Medicare and the Private Insurance Fund). There may be other fees, for example for members of the Health Team mentioned below.**

Approach to Fees – Known Gap

I participate in 'known gap' arrangements with private health insurers for hospital services.* 'Known gap' or other out-of-pocket cost information is in the 'Admitted (in-hospital) Consultations and Procedures' table below.	☐ Yes, always, for all insurers ☐ No or not always [Instruction to specialist: complete 'admitted' services table] ☒ Sometimes/Not always [Instructions to specialist: if 'known gap' is used sometimes, you should include an explanation in

	'Additional information' box below and complete the 'admitted' services table]

***For practitioners who participate in the known gap scheme for an MBS Item, there will be a capped maximum amount, which is commonly up to $500. HOWEVER, 'known gap' does not apply for some Private Health Insurance Funds and in some circumstances. To get accurate information for your particular case, it is important that patients contact their private health insurer to confirm your coverage and to confirm whether the fee will be fully covered. Health fund contact information can be found by clicking here**

Additional information about Fee charging practice
Dr xx undertakes most hospital surgical procedures under known gap arrangements where the patient's health fund allows.

This practitioner undertakes to charge only fees associated with a clinical service and Medicare item number, except for the following clinical services that do not attract a Medicare Benefit

……

The practitioner will not charge administrative, booking fees or any fees not associated with a clinical service

Non-admitted (out-of-hospital) Consultations and Procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Medicare Benefits Payable – 85% of Schedule Fee*	Most common out-of-pocket costs for Dr xx for this item*
104	Initial Consultation	$232/$186 (pens)	$73.85	$152
105	Subsequent Consultation	$140/$124 (pens)	$37.15	$98
109	Ophthalmology Consultation	$320	$166.35	$146
11221		$150	$57.60	$87
11241		$217	$88.15	$122
42575		$200	$70.55	$120
42614		$124	$41.10	$79
42615		$187	$61.45	$99
42738		$580	$240.60	$314
42788		$765	$300.35	$445

***If patients are eligible for Medicare Safety Net Payments, the Medicare benefit paid may be higher than 85% (and therefore the out-of-pocket cost reduced)**

Admitted (in-hospital) consultations and procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Most common out-of-pocket costs for Dr xx for this item*
42702	Cataracts	$1800	$500

*** The benefits paid by insurers, and the amount of any 'known gap', is not the same for all Private Health Insurance Funds or in all circumstances. To get accurate information for your particular case, it is important that patients contact their private health insurer to confirm your coverage and to confirm whether the fee will be fully covered. Health fund contact information can be found by clicking here**

EXAMPLE 5:

Medical Practitioner details

Name		
Specialty	Obstetrician	
Suburb		
State		
Website URL		
Consulting Rooms Private	Location	
	Phone Number	
Consulting Rooms Public Hospital	Name	
	Location	
	Phone Number	
Hospital Public	Name	
	Location	
	Phone Number	

Approach to Fees

I participate in 'no gap' arrangements with private health insurers for hospital services.*	☒ Yes, always, for all insurers [Instruction to specialist: no need to complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☐ No [Instruction to specialist: complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☐ Sometimes/Not always [Instructions to specialist: if 'no gap' is used sometimes, you should include an explanation in 'Additional information' box below, and complete the 'admitted' services table]

***For practitioners who participate in no gap schemes there will be no out-of-pocket costs (all of the fee is fully covered by Medicare and the Private Insurance Fund). There may be other fees, for example for members of the Health Team mentioned below.**

Approach to Fees – Known Gap

I participate in 'known gap' arrangements with private health insurers for hospital services.*	☐ Yes, always, for all insurers ☒ No

'Known gap' or other out-of-pocket cost information is in the 'Admitted (in-hospital) Consultations and Procedures' table below.	[Instruction to specialist: complete 'admitted' services table] ☐ Sometimes/Not always [Instructions to specialist: if 'known gap' is used sometimes, you should include an explanation in 'Additional information' box below and complete the 'admitted' services table]

***For practitioners who participate in the known gap scheme for an MBS Item, there will be a capped maximum amount, which is commonly up to $500. HOWEVER, 'known gap' does not apply for some Private Health Insurance Funds and in some circumstances. To get accurate information for your particular case, it is important that patients contact their private health insurer to confirm your coverage and to confirm whether the fee will be fully covered. Health fund contact information can be found by clicking here**

Additional information about Fee charging practice

Dr xx undertakes all hospital surgical procedures under no-gap arrangements where the patient's health fund allows. Uninsured patients can be offered care on his public hospital list.

Services in relation to assisted reproduction are provided through xxx and fee information can be found on their website xxx

This practitioner undertakes to charge only fees associated with a clinical service and Medicare item number, except for the following clinical services that do not attract a Medicare Benefit

None applicable

……

The practitioner will not charge administrative, booking fees or any fees not associated with a clinical service

Non-admitted (out-of-hospital) Consultations and Procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Medicare Benefits Payable – 85% of Schedule Fee*	Most common out-of-pocket costs for Dr xx for this item*
105	Subsequent Consultation	$100	$37.15	$62.85
16401	First obstetric visit including ultrasound	$200	$72.75	$127.25
16500	Antenatal attendance	$90	$40.10	$49.90
16514	Outpatient fetal CTG	$32.00	$31.20	80cents

16590	Overall management of pregnancy	$3000	$316.85	$2463.70
13209				
13218				
13200				

***If patients are eligible for Medicare Safety Net Payments, the Medicare benefit paid may be higher than 85% (and therefore the out-of-pocket cost reduced)**

Admitted (in-hospital) Consultations and Procedures

Dr xx participates in no gap arrangements at all times with all insurers. You will not be charged a gap payment.

Medicare Item Number	Descriptor	Out-of-Pocket Cost
104	Initial Consultation	$0
105	Subsequent Consultation	$0
16519	Birth	$0
16522	Complex birth	$0
35633	Complex hysteroscopy	$0
35637	Operative laparoscopy	$0
35640	Dilatation and curettage	$0
35616	Endometrial ablation	$0
35638	Complex operative laparoscopy	$0
13215		$0
13212		$0
35630		$0

Health Team

There may be other medical fees associated with your procedure. Dr xx generally works with the following specialists.

Anaesthetists	1	
	2	
	3	
Surgical Assistants	1	
	2	
Other Consultants / Specialists	1	
Medical Imaging	1	
Pathology	1	

EXAMPLE 6:

Medical Practitioner details

Name		
Specialty	Orthopaedic Surgeon	
Suburb		
State		
Consulting Rooms Private	Location	
	Phone Number	
Hospital Public	Name	
	Location	
	Phone Number	
Hospital Private	Name	
	Location	
	Phone Number	
Hospital Private	Name	
	Location	
	Phone Number	

Approach to Fees – No Gap

I participate in 'no gap' arrangements with private health insurers for hospital services.*	☒ Yes, always, for all insurers [Instruction to specialist: no need to complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☐ No [Instruction to specialist: complete 'Approach to Fees – Known Gap' or 'admitted' services table] ☐ Sometimes/Not always [Instructions to specialist: if 'no gap' is used sometimes, you should include an explanation in 'Additional information' box below, and complete the 'admitted' services table]

***For practitioners who participate in no gap schemes there will be no out-of-pocket costs (all of the fee is fully covered by Medicare and the Private Insurance Fund). There may be other fees, for example for members of the Health Team mentioned below.**

This practitioner undertakes to charge only fees associated with a clinical service and Medicare item number, except for the following clinical services that do not attract a

Medicare Benefit …… The practitioner will not charge administrative, booking fees or any fees not associated with a clinical service

Non-admitted (out-of-hospital) Consultations and Procedures

Medicare Item Number	Descriptor	Maximum fee charged by Dr xx	Medicare Benefits Payable – 85% of Schedule Fee*	Most common out-of-pocket costs for Dr xx for this item*
104	Initial Consultation	$87	$73.85	$12.25
105	Subsequent Consultation	etc	$37.15	$0

***If patients are eligible for Medicare Safety Net Payments, the Medicare benefit paid may be higher than 85% (and therefore the out-of-pocket cost reduced)**

Admitted (in-hospital) Consultations and Procedures

Dr xx participates in no gap arrangements at all times with all insurers. You will not be charged any out-of-pocket costs for Dr xx services. There may be other fees – see Health Team below

Medicare Item Number	Descriptor	Out-of-Pocket Cost
49318	Total Hip Replacement	$0
49518	Total Knee Replacement	$0
49324	Revision Total Hip Replacement	$0
49530	Revision Total Knee Replacement	$0
49560	Arthroscopy Partial Medial Meniscectomy	$0
49845	Arthrodesis of MTPJ Great Toe	$0
39331	Carpal Tunnel Release	$0
49851	Claw toe correction	$0
39330	Neurolysis without transposition	$0
39321	Transposition of Nerve	$0

Health Team

There may be other medical fees associated with your procedure. Dr xx generally works with the following specialists. See individual specialist information on their webpage on this website, or follow link below to corporate websites.

Anaesthetists	1	
	2	
	3	
Surgical Assistants	1	

	2	
Other Consultants / Specialists	1	
	2	
	3	
	4	
Medical Imaging	1	
	2	
Pathology	1	
	2	

Attachment F

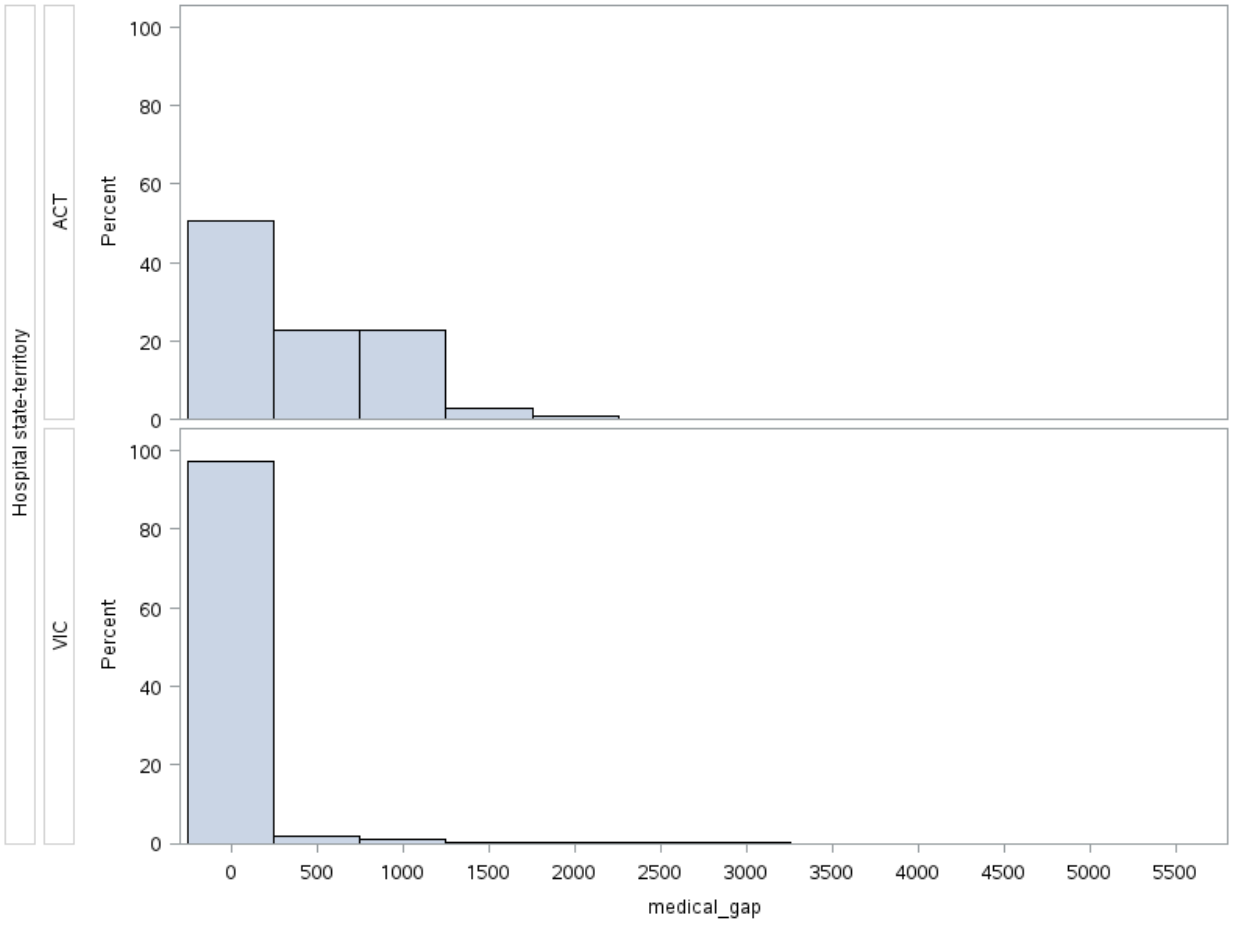
Examples for Option1b – Aggregated Out-of-Pocket Costs Data – Government Historical Data

1. Aggregated data by MBS item

MBS item XXX,

This figure shows that, for MBS Item XXX:

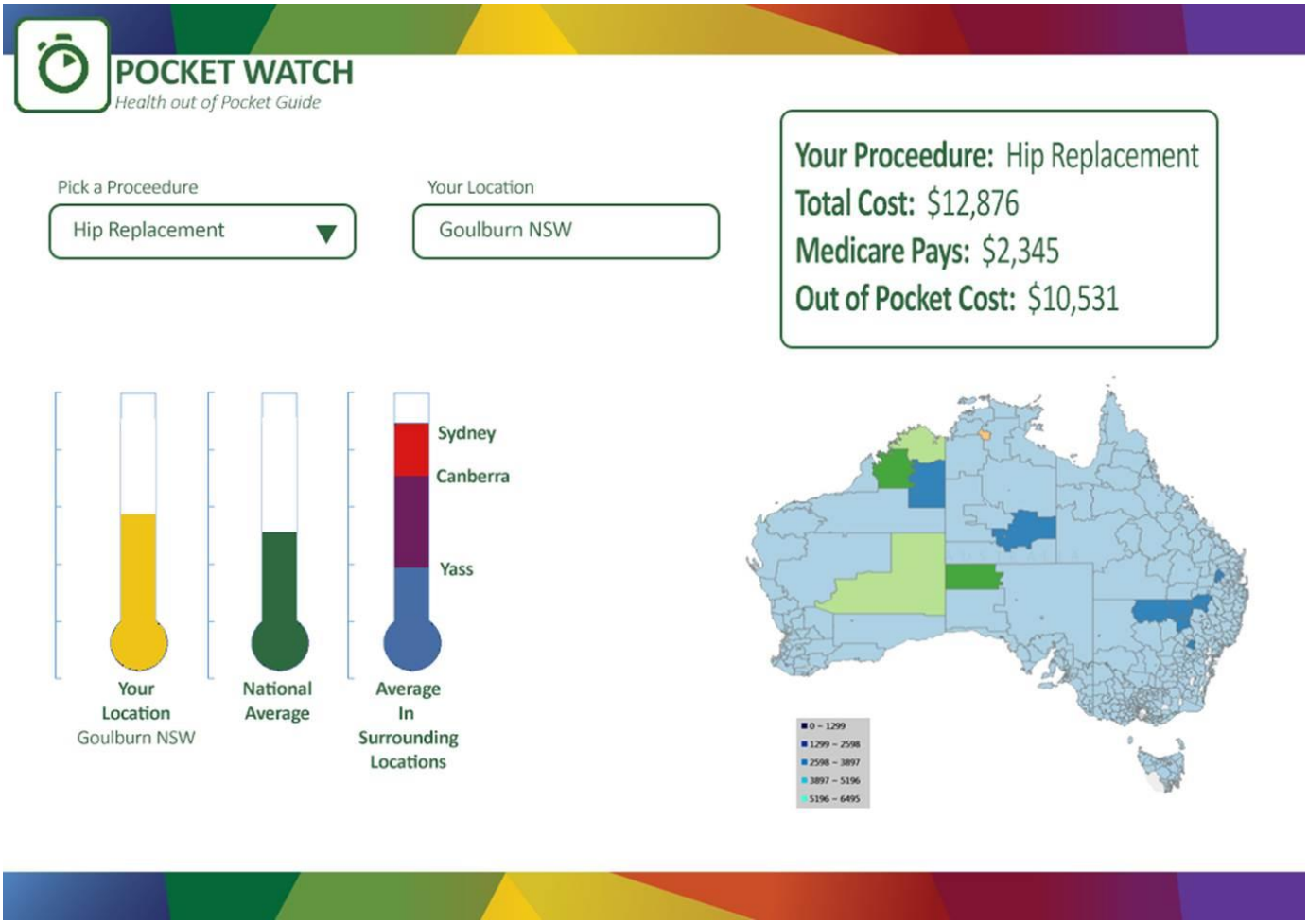
- in ACT, around 50 per cent of medical specialists charge fees that result in no gap, around 20 per cent have $500 to $1,000 out-of-pocket costs, and a small number charge fees that result in $1,500 to $2,000 out-of-pocket costs.
- in Victoria, almost 100 per cent of medical specialists charge fees that result in no gap, and where there are out-of-pocket costs, they are usually $500 to $1,000.



Aggregated data by major procedure

The example below shows a potential Out-of-Pocket prototype that includes aggregation of MBS items commonly used for major procedures.

The user can choose from a drop-down procedure list and address box to receive a set of graphics showing cost comparison and procedure costs.



Attachment G

Table 1: Number and percentage of MBS items, within service provider state/territory, potentially requiring suppression from publication, 2016-17

Service provider state/territory	MBS items that may need to be suppressed	Total MBS items	% Items that may need to be suppressed
NSW	1,290	5,100	25.29
VIC	1,312	4,871	26.93
QLD	1,377	4,750	28.99
SA	1,851	4,152	44.58
WA	1,608	4,318	37.24
TAS	1,824	3,391	53.79
NT	1,503	2,158	69.65
ACT	1,849	2,954	62.59