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POSITION STATEMENT

Principles for private health insurer contracting with medical practitioners

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Introduction

This position statement outlines the Australian Medical Association's position on the principles that should govern private health insurer contracting with doctors.

Currently, approximately 97 per cent of medical procedures performed in private hospitals are conducted by doctors working under 'no gap' or 'known gap' agreements with private health insurers.

Under 'no gap' agreements, doctors agree to set their fee at the amount the insurer is willing to pay the patient as a benefit for medical treatment. Under 'known gap' agreements, doctors agree to charge the patient the amount the insurer is willing to pay the patient, plus a 'known gap' — up to a maximum amount, unilaterally determined by the insurer.

In the delivery of maternity services and joint arthroplasty in private health settings, health funds are also seeking to introduce a system of bundled contracts. In this context, bundled contracts refer to an insurer's expectation that a 'lead practitioner' will negotiate a single, collectively agreed price with all other practitioners likely to be involved in the patient's care — from the antenatal stage through to birth, or from referral through to outpatient rehabilitation.

The AMA is increasingly concerned about the lack of regulation governing contracts between insurers and medical practitioners — particularly their potential impacts on patient choice and quality of care, the clinical autonomy of doctors in private practice, private hospital case mix, and other health professionals involved in the patient's care.

At present, there is no fit-for-purpose regulator with the mandate or resources to set the rules for contracting arrangements between private health insurers and doctors, or to provide adequate oversight of how these contracts are evolving. Concerningly, many insurers require doctors to keep contract details strictly private under 'commercial-in-confidence' provisions.

The AMA is concerned that this lack of regulation and oversight is leading Australia toward a future in which medical costs are controlled by funders limiting the services doctors and hospitals offer.

If Australia is to maintain its record as having one of the best healthcare systems in the world — where patients have both choice of provider and excellent health outcomes — any further shift

toward managed care must be prevented through effective regulation of what private health insurers are permitted to do to control their costs.

Principles that should define contracting between private health insurers and doctors

1. The need for a fit-for-purpose regulator and regulations

1.1 Under the *Private Health Insurance Act 2007* and subordinate legislation, there are essentially no regulatory safeguards around the way private health insurers contract with doctors. Nor are there any real safeguards to prevent the top five private health insurers — which collectively control more than 80 per cent of the Australian private health insurance market — from abusing their market power in contract negotiations. In addition, while insurers have teams of lawyers available to draft and review contracts, doctors generally do not have access to comparable resources and often find themselves entering undesirable contracts or drawn into lengthy negotiations.

1.2 The Australian Competition and Consumer Commission (ACCC) conceded this in 2021 in its draft decision on Honeysuckle Health and nib by saying 'there is no specific regulatory oversight or limitation on how parties contract with each other in the medical supply chain, and any such limitation (for example, to prevent value-based contracting) would be a matter for Government, through the Commonwealth Department of Health, to determine'.

1.3 The ACCC has neither the authority nor the resources to consider the impact of private health insurer contracting and commercial behaviour on healthcare quality and safety. It sees its remit as ensuring consumers have a choice to take out private health insurance and to select their private health insurer, their medical practitioner, and the hospital at which they are treated, on the basis of criteria that matter to the individual consumer — be that price, location, or some other criterion.

1.4 Currently, there is also no regulatory prohibition on private health insurers establishing or buying businesses that provide healthcare. This is a massive conflict of interest and a matter of mounting concern following increases to capital reserve requirements imposed by the Australian Prudential Regulatory Authority. This change has seen many of the large insurers using their profits to invest in the purchase or establishment of health service businesses.

1.5 Self-regulation by insurers is insufficient to provide certainty to consumers with respect to the value of private health insurance, or to provide certainty to health service providers, patients, and governments as to the quality and safety of healthcare services and the integrity of private health insurers' conduct.

1.6 The self-regulatory Private Health Insurance Code of Conduct, initially developed by for-profit insurers in an attempt to fend off further regulation in the lead-up to the 2017 Senate Committee inquiry into the value and affordability of private health insurance, focuses entirely on insurer relationships with patients and intermediaries, such as insurance comparison websites. It says nothing about insurer relationships or contracts with hospitals and doctors.

1.7 Given there is currently no regulator in the health sector with oversight of all aspects of the private health system — let alone the Australian health system as a whole — the AMA has for

several years been calling for the establishment of a statutory, independent, and well-resourced Private Health System Authority.

1.8 A Private Health System Authority must have the authority to gather all the data required to develop an evidence-based overview of the private health system, in the context of the Australian health system as a whole, and to provide patient-centred, independent, evidence-based advice to government about future directions for the sector.

1.9 Once established, a Private Health Systems Authority should develop a standard set of terms of conditions for private health insurers' 'no-gap' and 'known-gap' contracts with doctors, ensuring these contracts comply with relevant legislation and are transparent and fair to all parties.

2. Clinical autonomy

2.1 Above all, it is critical that private health insurer contracts with doctors do not interfere with the treating medical practitioner's clinical judgement regarding the treatment, procedure, or prosthesis a patient needs; where that treatment should be provided; or how urgently the patient should receive it to safely and effectively treat their medical condition.

2.2 The assurance that a consumer with an appropriate level of private health insurance cover will be able to obtain high-quality, safe, clinically appropriate and timely care from a medical practitioner of their choice is central to the value proposition of private health insurance. This must not be eroded by private health insurer contracting practices.

2.3 Private health insurers must not be permitted to create their own 'clinical guidelines' to dictate the treatment they believe is appropriate for any patient, or to deny patient benefits for treatment they do not deem appropriate. This function is appropriately fulfilled by medical colleges and societies, not insurers.

2.4 To ensure the delivery of safe, appropriate and high-quality care, medical practitioners must not be required to seek 'pre-authorisation' of procedures from private health insurers. Where artificial intelligence is used to disallow or deny claims, appropriate appeals processes — including human review — must be easily accessible.[i]

3. Adequate indexation of private health insurer benefit rates

3.1 Doctors' medical fees must cover income, staff wages, medical indemnity insurance, and practice costs (including rent, medical supplies, telecommunications, and equipment). Each of these costs has risen year on year, outstripping MBS indexation. This has contributed to a growing gap between MBS rebates and the actual costs of providing healthcare in Australia.

3.2 Increases to rebates for treatment provided by private health insurers have tended to track increases in MBS rates. This means that they, too, have fallen considerably in real value over the years, even as private health insurance policy premium charges to consumers have continued to rise — often, more recently, at a rate greater than CPI.

3.3 This reduces the value proposition of private health insurance to consumers, often leaving them with large out-of-pocket costs to pay.

3.4 To ensure the Australian private health system has the capacity to continue providing safe, high-quality care, and to maintain the value proposition of private health insurance for consumers,

private health insurer contracts with doctors must be appropriately indexed to the increasing costs of medical care provision. The known gap limit of $500 has not been indexed since it was introduced in the early 2000s.

4. Non-price terms in private health insurer contracts with doctors

4.1 **Confidentiality:** To promote transparency and appropriate scrutiny by regulators, members of the public, and other medical practitioners, private health insurers must be prohibited from requiring confidentiality in their contracts with medical practitioners.

4.2 **'Take it or leave it' insurer contracts:** Insurers must be prohibited from offering doctors 'take it or leave it' contracts. This is in part because of the massive differential in power between individual doctors and insurers, where the latter may have teams of lawyers at their disposal.

4.3 **Impact on patient costs:** Furthermore, the impact of the doctor not signing 'take it or leave it' contracts (e.g., 'no gap' or 'known gap' contracts) on patient out-of-pocket costs can be significant. One example is that insurers greatly reduce the medical benefits payable to the patient if the doctor charges even $1 more than the insurer is willing to pay under a 'no gap' or 'known gap' contract.

4.4 **Restrictions on the hospitals where contracted doctors may provide treatment:** Insurers must not restrict where contracted doctors can perform services. This is necessary to mitigate the risk of vertical integration and the channelling of doctors to contracted hospitals. The location of care should be driven by patient choice and clinical appropriateness.

5. Bundled contracts

5.1 The AMA does not support private health insurers offering doctors 'bundled' contracts for care that would require a group of clinicians to agree to a single, collectively determined price for the care of any patient's medical condition or procedure.

5.2 The AMA also does not support 'bundled' models of private health funding that would attempt to roll funding for medical services provided by independent private practitioners for any patient's medical condition or procedure into funding for private hospitals for the same medical condition or procedure.

5.3 Clinicians in private practice must be free to provide medical services in the hospital, facility, or setting the patient prefers, even if the patient's health fund does not have a contract with that hospital, facility, or setting, without it affecting the medical benefits the health fund pays to the patient for the medical services provided by their clinical care team.

See also:

AMA 2024 Private health insurance report card
AMA repeat prescription for private health insurance

[i] https://www.cbsnews.com/news/health-insurance-humana-united-health-ai-algorithm; https://www.cbsnews.com/news/unitedhealth-lawsuit-ai-deny-claims-medicare-advantage-health-insurance-denials[i]; https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims