medibank
For Better Health

Medibank Submission

CONSULTATION ON METHODOLOGY FOR DETERMINING THE BENCHMARK PRICE FOR PROSTHESES IN AUSTRALIA

1.10.2021

Contents

medibank
For Better Health

Executive Summary

Medibank appreciates the important work that IHPA is undertaking to support the Prostheses Reforms. We agree that:

> "The prices charged for medical devices in the private health care system, mandated by the current Prostheses List (PL) in most cases, far outweigh the costs of the same items in other competitive markets including the public hospital system. In 2019–20, some costs were up to 145 per cent higher."

This has a direct impact on the cost of healthcare in the private sector and on PHI premiums paid by millions of Australians.

Fundamentally, lower prostheses expenditure means lower private health insurance premium increases – it's that simple. All other things being equal, every $200 million in prostheses benefit reductions will decrease private health insurance premiums by one per cent.

However, we note that previous attempts at reform have failed to deliver the anticipated savings to insurers, despite insurers passing these savings on to customers through lower premiums. The MTAA-Government October 2017 Agreement was initially supposed to deliver industry savings of $188m p.a. following initial price cuts to the Prostheses List (PL) in February 2018. However, promised savings were entirely eroded by FY2019 due to growth in the volume of prostheses items used.[1]

Whilst Medibank broadly supports the proposed methodology for calculating the benchmark prices, we encourage IHPA to consider the following:

- IHPA should collect sufficient data to enable it to calculate a public hospital benchmark price at a prostheses item, prostheses category and patient episode level. The data relied on and these calculated benchmarks must be publicly disclosed for transparency. Whilst adopting a volume-weighted approach is reasonable, we recommend IHPA provide commentary and publicly disclose when lower benchmark prices for items and categories are materially different from the volume-weighted average.
- DRG-level prostheses cost data collected as part of the National Hospital Cost Data Collection (NHCDC) should be used alongside purchase price data from States and Territories. We are concerned about the primary data source from which the benchmarks are derived. IHPA has embarked on this mammoth task of collecting primary data from alternate sources, under tight timeframes and the risk to manage is data relevance, quality and accuracy with two of these data sources never being used before.
- International benchmark prices, for high value categories such as Drug eluting stents, Hip and Knee Joint replacements, Spinal implants and Pacemakers should be reviewed in conjunction with public hospital data and IHPA should provide commentary wherever prices in international markets are materially different from its calculated public hospital benchmark price. This will provide a useful point of comparison with markets where prices will not have been potentially distorted by the existence of the Prostheses List (PL). In New Zealand, prices for drug eluting stents from the four largest suppliers' range between 30% to 65% of the price on the Prostheses List (PL).[2]
- There is no legitimate reason why PHI customers should pay higher prices for devices compared with other markets, including comparable international markets and the public hospital sector. Any private hospital 'margin' that remains to keep prices on the Prostheses List (PL) higher is a transfer from PHI customers to device companies (mostly large multi-nationals) and will only serve to keep premiums higher than they need to be.

[1] PHI industry data from APRA, Medibank analysis. In FY19 the number of prostheses items per hospital episode grew 8.6%. The average benefit per prostheses dropped by 8.5%, mainly due to the legislated price cuts. The volume growth entirely eroded industry savings

[2] Evaluate *"The Prostheses List: Reprised"* March 2021

Medibank is open to an independent audit of industry savings from lower prostheses expenditure and the impact of such savings on premiums. It is up to the device manufacturers to be open and transparent on their pricing and margins.

About Medibank

Medibank is one of Australia's largest providers of private health insurance, with more than 40 years' experience delivering better health to Australians. We look after the health cover needs of 3.7 million Australians through our Medibank and ahm brands and deliver a range of programs to support health and wellbeing in the community.

Medibank is committed to improving the value of health insurance for Australians and to strengthening our health system.

Our Business

Headquartered in Melbourne, Medibank has corporate offices in Canberra, Brisbane, Perth, Sydney, and Wollongong. We have more than 80 retail stores across Australia, with over 20 in regional areas, employ over 3,900 people, and handle more than 40,000 phone inquiries a week.

For the 2020-21 financial year, Medibank grew its resident policyholders by 82,500 and record customer advocacy levels for the Medibank brand (37.1) and the ahm brand (43). Medibank recorded a net profit of $441 million and paid $191 million in tax. Around 270,000 Australians own shares in Medibank.

For more than a decade, Medibank has been collaborating with hospitals, doctors and governments on innovative ways of delivering care in the home and community. Medibank is Australia's leading telehealth provider and delivers in-home care through its wholly owned subsidiaries HealthStrong and Home Support Services. Medibank employs over 1,500 health professionals across Australia, delivers 800,000 nurse advice calls for Australians and 70,000 GP tele-consultations per year as part of the more than 2.5 million interactions a year we deliver through our telehealth and digital health services.

Medibank is focussed on delivering health services, not just health insurance, with our CareComplete program supporting around 37,000 people with chronic disease in partnership with numerous State Governments. As part of our joint venture with Calvary, we are delivering My Home Hospital, a Wellbeing SA service, which brings together remote monitoring technology to enable real time tracking of a patient's clinical status at home and allows the care team to stay in touch.

More than 40% of our board and more than half of our senior managers are women. We are committed to increasing the representation of people with disabilities, Indigenous Australian Peoples, and those aged over 55 within our workforce.

Medibank's Commitment to Deliver Value for Our Customers

Medibank has a fundamental stake in the health and wellbeing of our 3.7 million customers. We spent $5.6 billion on our customers' healthcare in 2021, supporting more than 1.1 million hospital admissions, 25.9 million ancillary services like dental and optical, and more than 430,000 surgical procedures.

Medibank knows that affordability of private health insurance is a real issue for many Australians. That is why our premium increase for 2021 is the lowest in 20 years. We are working hard to deliver greater value to our customers and to address the affordability challenges that the private healthcare industry faces. Some of our recent initiatives to bring greater value for our customers include:

- Providing more than $300 million in support for our customers during COVID-19, including ongoing hardship measures for those doing it tough.
- Delivering more personalised services to our customers to improve their quality of life, help them to stay out of hospital (e.g. non-hospital palliative care, rehabilitation and chemotherapy), and take pressure off premiums and the healthcare system.
- Investing in our CareComplete program to improve chronic disease management, collaborating with more than 3,600 GPs to reduce avoidable hospitalisation for people with chronic health needs.

- Managing our own costs to help keep premiums low – we have delivered around $20 million of savings through our productivity program in 2020 and are targeting a further $50 million over the next three years.

Responses to Consultation Paper Questions

1. Which data source should IHPA utilise as the primary data source for determining the public sector benchmark price?

The differences in purchasing arrangements between the private sector and the public sector adds complexity to which data source IHPA should use as its primary source.

To gather more granular item-level prostheses prices, Medibank supports the use of purchase price data from States and Territories (as opposed to data supplied by device sponsors, discussed below) as it reflects what the public sector spent on prostheses at a granular level. Benchmarks will need to be set at an appropriate comparable category level i.e. all items within the same comparable category, delivering the same clinical outcomes contributing to the benchmark price, which is the weighted average price for those items. Should the benchmarks be done at this category level, one can apply the benchmark price to the comparable category in the Prostheses List (PL) and all items within that category should be well within that benchmark price. This will make the findings easily transferrable to the private sector.

As this dataset has not previously been collected for critical decision-making and the quality of it has yet to be verified, nor does it necessarily reflect the actual prostheses costs for comparable treatment in the public sector, this data should be supplemented with a comparison of the actual prostheses costs between the private and public sector. The best source of comparison for this would be the already validated episode-level data from the National Hospital Cost Data Collection (NHCDC) for public hospital prostheses costs, and Hospital Case-mix Protocol (HCP) data for private hospital prostheses costs. IHPA should then compare the difference in actual prostheses costs in the public and private sector with the observed differences in prices between purchase price data from States and Territories and the Prostheses List (PL).

We do not believe that actual prostheses costs in the private sector should be any higher than those in the public sector, unless there is evidence of better outcomes for patients in the private sector due to the selection of higher cost devices and/or the number of devices used. We are not aware of such evidence. However, evidence published National Joint Replacement Registry (NJRR) in the ANZ Journal of Surgery showed higher revision rates in private hospitals compared with public hospitals which the authors largely attributed to prostheses selection in the private sector. [3]

We have strong reservations using any data coming directly from device sponsors and concerns that there may be a lack of full transparency given the vested interest in the outcomes of this exercise. It will be useful however to compare the purchase data to the sales price data received from the Medical Technology Association of Australia (MTAA), hereafter. There may be useful insights and questionable differences in outcomes should each of these be selected as the primary source of truth. It is however still preferable to use the public sector purchase data as it is likely easier to work with a few procurement companies across the different States to ensure the integrity of the data. It is also not clear if the market share adjustments and various discounts that should be applied to the prices are adequately adjusted for in the sales price data but will be considered in tender prices.

In summary, we recommend that IHPA collects sufficient data to enable it to set a public hospital benchmark price at different levels of granularity, including:

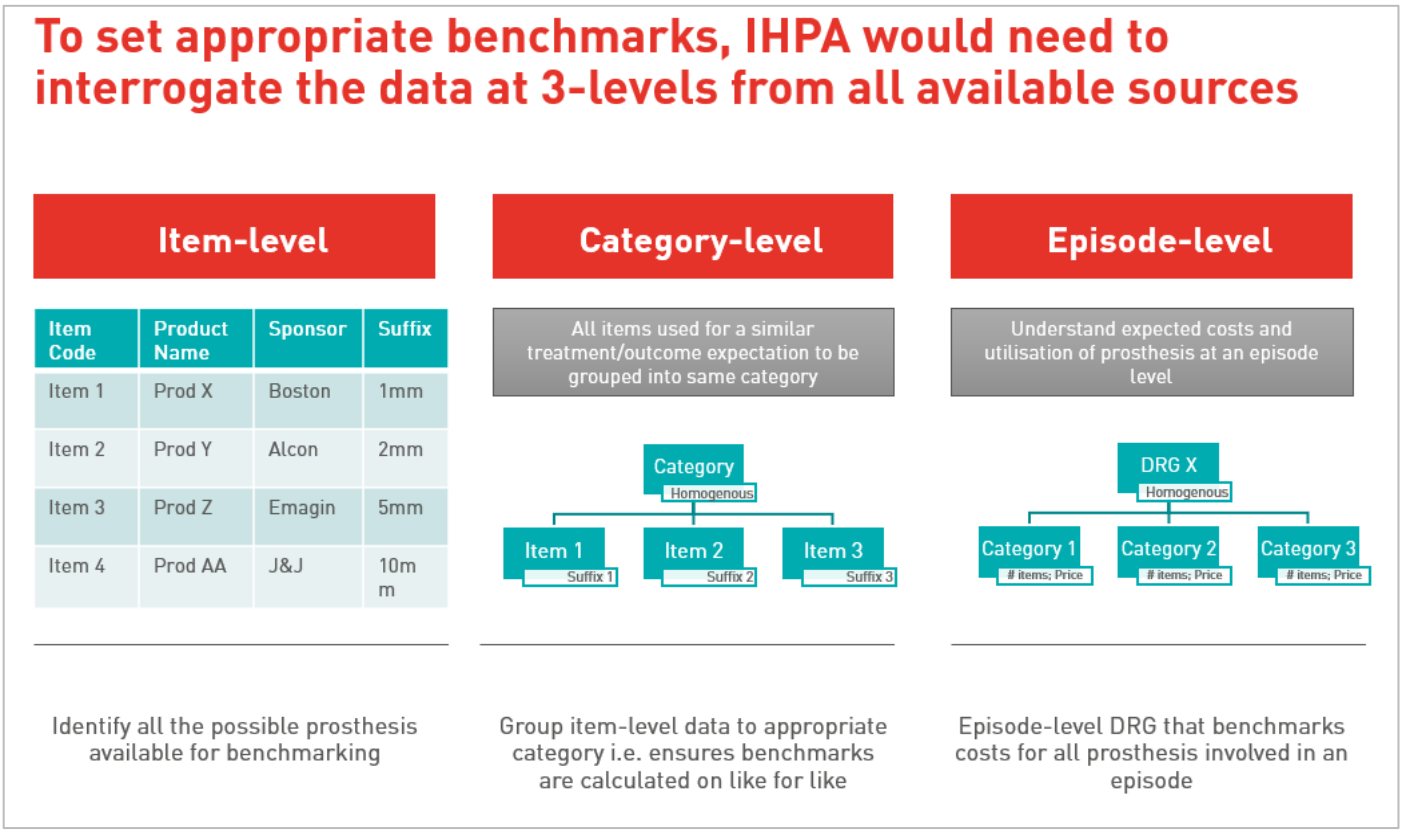
1. identify all individual prostheses items that will be included in the benchmark.

[3] Harris I, Cuthbert A, Lorimer M, de Steiger R, Lewis P and Graves S., Outcomes of Hip and knee replacement surgery in private and public hospitals in Australia. *ANZ Journal of Surgery,* 2019.

2. the benchmark price for a prostheses category (e.g. grouping together different items that deliver the same treatment and similar clinical outcomes and weighting for their relative utilisation in the public sector).
3. the benchmark price for prostheses costs for an episode of care.

These benchmarks as well as the data relied on to calculate them should be publicly disclosed to support transparency. See below for an illustration of the data requirements.

Figure 1 Prostheses Benchmarking data requirements using illustrative data



2. Are there any other sources of data IHPA should consider for determining the public sector benchmark price?

As per our response above, we strongly recommend that IHPA utilises DRG-level data of actual prostheses costs, in addition to data collected from States and Territories for the costs of prostheses items. In addition, IHPA should consider international benchmark pricing to ensure in addition to assessing private to public performance we also consider our overall relative performance against international markets. At the very least, this should be pursued for high value prostheses categories e.g. Drug eluting stents, Hip and Knee Joint replacements, Spinal implants and Pacemakers. In New Zealand, prices for drug eluting stents from the four largest suppliers' range between 30% to 65% of the price on the Prostheses List (PL).[4]

In addition to price, volume and mix, we would also suggest looking at data on clinical outcomes and effectiveness and an evidence-based approach to pricing e.g. revision rates related to one orthopaedic device relative to another so the discussion on what's included in the PL list also hones in on clinical effectiveness.

Market prices are also influenced by the players in the market i.e. monopoly, duopoly or oligopoly markets will have different price outcomes. IHPA should understand the impact of competitive vs. non-competitive vs.

[4] Evaluate *"The Prostheses List: Reprised"* March 2021

incomplete markets in driving market prices for devices and create benchmarks appropriately with hindsight of market forces driving prices in different areas.

3. What risks should IHPA consider if DRG level information were to be utilised? Are there alternative approaches IHPA should consider?

We support IHPA utilising DRG-level information on actual prostheses cost using National Hospital Cost Data Collection (NHCDC) data to inform the public hospital benchmark price. The key consideration is how DRG-level prostheses cost information can be applied to the item-based Prostheses List (PL). We recommend that IHPA use DRG-level information alongside item/category-level information, as well as any available information on clinical outcomes in setting their benchmark price. We also recommend IHPA focus on DRG-level information for the common, high value prostheses areas including Drug eluting stents, Hip and Knee Joint replacements, Spinal implants and Pacemakers.

Below we include some additional consideration relating to DRGs that are relevant when analysing and interpreting this data.

A DRG is a clinically homogenous risk cell that can accommodate varied level of services within the same DRG that on average assume a similar resource usage. More complex patients are described by the DRG severity level and should represent the resource needs even for prostheses appropriately. All factors that influence the volume and cost of prostheses should be included in the risk cell that determines the benchmark price. The only other two factors that would be considered are age and State. Some prosthetic items may be more favourable to older individuals vs. younger individuals with expected lifespan of use, therefore age should be considered. Price variation by State is expected due to the different State procurement groups and agreements and should be included in addition to age, although there may be a case to volume weight the device costs overall, to provide a single price overall. This is also important if device sponsors incur losses in some States for the same products, they are making profits in other States.

The DRG is sourced from the National Hospital Cost Data Collection (NHCDC) which reflects current utilisation based on what's available from State/LHN tendering arrangements and influenced by clinician's current choices. It does not consider what items are exhaustively available that are potentially more cost efficient relative to current utilisation. The definition of the "most clinically appropriate' prostheses item is likely to be highly subjective and may not be feasible for IHPA to undertake fairly.

4. Do you support IHPAs proposal to establish the public sector benchmark price using a volume weighted average approach? Please provide rationale

We are broadly supportive of the proposal to use a volume weighted average approach. The benchmark price should be based on the weighted average price of all prostheses' items within the same category. Weighting allows the items that are more readily used to have a higher influence over the price compared to items that are available and not readily used. One would also expect that higher volume devices are available at already discounted prices and we would be keen to understand if this is the case. One also assumes that for all items in a comparable category, they all have comparable clinical effectiveness, however this is yet to be analysed and proven.

We would suggest narrowing down the focus and further scrutiny to high value prostheses categories e.g. Drug eluting stents, Hip and Knee Joint replacements, Spinal implants and Pacemakers. In this way we deal with the critical areas of high importance to private sectors' prostheses costs and utilisation.

If episode level data is to be utilised (as is our strong recommendation), we suggest using an appropriately case-mix adjusted population that more appropriately represents the private sector needs versus that of the public. Immediate considerations would be geographic locale (private facilities are overwhelmingly metropolitan based) if, for example, freight costs are a significant input in the cost of prostheses. This could be supplemented with purchase price data from LHNs that meet these geographic characteristics so that

costs are not biased by larger States with higher proportions of remote/regional LHNs. Further population adjustments would need to address the case-mix distribution of the private patient population, e.g., lower average risk profile, and removal of high-cost and rare diagnostic categories, for example, Burns and Transplantation.

The one thing to consider though, is that new to industry device sponsors with clinically and cost-effective prostheses devices, having low utilisation will not influence the benchmark as much as they could. In a perfectly competitive market, new suppliers would be allowed to enter the market based on more competitive prices, however given low historic utilisation, these devices would not heavily influence or be ignored altogether from the benchmarking.

5. Are there any alternative approaches that IHPA should consider? Please provide rationale

There are several alternatives to adopting a volume-weighted approach that IHPA should consider so that the Prostheses List (PL) pricing reflects the benefits from ongoing innovation and price competition.

For example, an alternative benchmark could include the weighted average price of the top 25th percentile (in terms of affordability) of prostheses items within a specific category.

Alternative approaches could be looking at specific market segments not influenced by market competitive factors like monopolies and calculating the weighted average over that subset.

It would also be useful to understand regional variation in benchmark prices within LHNs in the same State and by States overall just to understand the impact of bargaining occurring at a regional level. IHPA could decide to benchmark prices based on the best regions.

As previously discussed, for high volume/high value areas of the Prostheses List (PL), it is advisable to compare to international benchmarks. This will unpack the level of competitiveness within the Australian market relative to international markets. In particular, prices in NZ, which geographically is a very close market to Australia and hasn't had the distortionary impacts of the Prostheses List (PL) on prices.

6. What factors, if any, should be considered as legitimate and unavoidable difference between the private and public hospital systems with respect to prostheses pricing?

We do not believe there are any legitimate and unavoidable differences between the private and public hospital systems that should lead to differences in prostheses pricing. Specifically, we are not aware of any evidence of additional service levels in the private sector that leads to higher costs, nor that this leads to better clinical outcomes for patients.

Influences that need to be considered but not necessarily adjusted for:

- Basket of prostheses items per product category and difference in prostheses utilisation as the Prostheses List (PL) governs what is currently utilised in the private sector vs. targeted procurement at a State level in the public sector
- State differences/Rural vs. Metro and prostheses choices based on patient age
- Case-mix of private population versus that of public population
- Market share and volume discount differences between public and private sector influence the price of items. The shape of utilisation likely different between private and public and they not operate under the same market dynamics
- Product category pricing discounts also skew the price of prostheses in public sector relative to private
- Special provision of prostheses items at discounted prices to public sector on compassionate grounds, not applicable in private sector
- Potential rebate differences between private and public sector

7. How should the extent of any such differences be quantified?

We do not agree that there are any legitimate and unavoidable differences in the costs of prostheses between the public and private hospital sector and as such we do not support trying to quantify any differences.

Conclusion

Whilst Medibank broadly supports the proposed methodology for calculating the benchmark prices, we encourage IHPA to consider the following:

- IHPA should collect sufficient data to enable it to calculate a public hospital benchmark price at a prostheses item, prostheses category and patient episode level. The data relied on and these calculated benchmarks must be publicly disclosed for transparency. Whilst adopting a volume-weighted approach is reasonable, we recommend IHPA provide commentary and publicly disclose when lower benchmark prices for items and categories are materially different from the volume-weighted average.
- DRG-level prostheses cost data collected as part of the National Hospital Cost Data Collection (NHCDC) should be used alongside purchase price data from States and Territories. We are concerned about the primary data source from which the benchmarks are derived. IHPA has embarked on this mammoth task of collecting primary data from alternate sources, under tight timeframes and the risk to manage is data relevance, quality and accuracy with two of these data sources never being used before.
- International benchmark prices, for high value categories such as Drug eluting stents, Hip and Knee Joint replacements, Spinal implants and Pacemakers should be reviewed in conjunction with public hospital data and IHPA should provide commentary wherever prices in international markets are materially different from its calculated public hospital benchmark price. This will provide a useful point of comparison with markets where prices will not have been potentially distorted by the existence of the Prostheses List (PL). In New Zealand, prices for drug eluting stents from the four largest suppliers' range between 30% to 65% of the price on the Prostheses List (PL).[5]
- There is no legitimate reason why PHI customers should pay higher prices for devices compared with other markets, including comparable international markets and the public hospital sector. Any private hospital 'margin' that remains to keep prices on the Prostheses List (PL) higher is a transfer from PHI customers to device companies (mostly large multi-nationals) and will only serve to keep premiums higher than they need to be.

Medibank is open to an independent audit of industry savings from lower prostheses expenditure and the impact of such savings on premiums. It is up to the device manufacturers to be open and transparent on their pricing and margins.

[5] Evaluate *"The Prostheses List: Reprised"* March 2021