Study of private health insurance minimum and second-tier default benefit arrangements

Final report

Australian Government Department of Health and Aged Care

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Building a better working world

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1. Executive summary

1.1 Purpose of default benefits

Main purpose[1] of default benefits[2]

The main purpose of default benefits is to safeguard private health insurance (PHI) policyholders' access to, and choice between, private hospitals for private health insurance-funded services. In doing so, default benefits aim to promote equity between consumers by providing a guaranteed level of financial support for hospital treatment, whilst allowing insurers to provide a level of differentiation between private hospitals via contracting.

Default benefits have been designed with the intention of meeting this purpose by ensuring a legislated level of private health insurer (insurer) funding to hospitals in cases where a contract has not been agreed upon between the hospital and the consumer's insurer.

Although there is general consensus on the main purpose, the need for, and design of, the legislated level of insurer funding is highly contentious.

The need for legislative intervention in establishing default benefits arises from the risks that, in their absence:

- Consumer choice might be limited if some private hospitals are unable to agree contracts with insurers
- Consumers may face larger hospital out-of-pocket costs in order to access the healthcare services required to meet their health needs, and/or
- Consumers may forego private healthcare services, potentially compromising their health outcomes or impacting on the public healthcare system.

Other purposes of default benefits

Default benefits, specifically minimum benefits,[2] also have two other purposes in providing a funding mechanism to support two other policy areas:

- Private patients in public hospitals, and
- Private Health Insurance (PHI) product design – especially where the consumer's product offers "restricted" coverage for certain service types.[3]

These uses differ from the main purpose as, in these settings, minimum benefits are not an alternative to contracting but are the only mechanism through which insurers fund these services.

[1] Although there is no explicit stated purpose to default benefits in Private Health Insurance (PHI) legislation, we have inferred their main purpose from their design and through stakeholder consultation.

[2] Default benefits refer to minimum benefits and second-tier benefits. Minimum benefits are an amount the insurer is required to pay for a hospital admission that is covered on a PHI policy. Second-tier benefits are a benefit amount paid to second-tier eligible hospitals where a contractual agreement between the insurer and hospital is not in place. Refer to Section 1.4 for further definitions of default benefits, minimum benefits and second-tier default benefits.

[3] Restricted benefits are where a hospital and insurer have a contractual agreement but the PHI product the consumer holds does not offer coverage for a required service type, for example rehabilitation or psychiatric services.

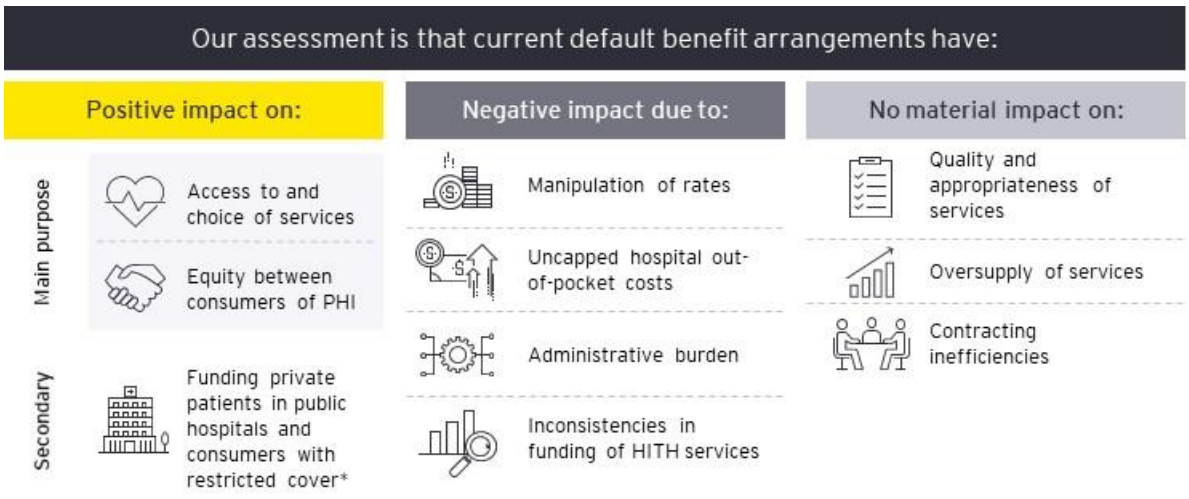
Default benefits' interaction with the safety and quality of services

By safeguarding choice, default benefits support consumers in accessing quality and value in healthcare services. A feature of second-tier default benefits is their eligibility requirements, intended to support higher quality/better value healthcare services. The Australian Commission on Safety and Quality in Health Care (ACSQHC) and State and Territory licensing/registration regulators contribute to ensuring minimum safety and quality standards are in place. However, adequate hospital funding is required to ensure safety and quality standards can be met. Therefore, there is an interaction between these requirements that needs to be continuously considered.

We consider that safety and quality matters should be considered in the context of the national safety and quality standards and framework, supported with adequate private hospital funding through default benefits and contracting. Issues relating to the safety and quality of default benefit-funded services should not solely be considered as an indication of the ineffectiveness of default benefits.

1.2 Findings: current state

Figure 1: Assessment of current default benefit arrangements



** There are concerns around the benefit of restricted cover for consumers. However, default benefits do support the current policy of restricted benefits.*

Default benefits are an important component of the private healthcare system in safeguarding access and choice and supporting equity. However, there are range of other policy and funding mechanisms that have significant impacts on the supply and demand for private healthcare services, meaning that default benefits cannot be expected to achieve optimal access, choice and equity alone.

In our view, as a mechanism that safeguards consumers to receive insurer funding for private hospital services, default benefits are effective in supporting their main purposes. Other broader changes to environmental settings outside of default benefits would be required to have a direct additional positive impact on access, choice and equity.

However, the effectiveness of default benefit arrangements would be optimised by making changes to the arrangements that reduce or eliminate the negative impacts outlined in Figure 1.

Positive impacts: how default benefits support their main purpose

Our assessment found that default benefits are effective in supporting their key purpose of safeguarding consumer access and choice. In the case that contracts cannot be agreed, default benefits can and do act as a funding safety net and support the continued provision of services for consumers, with insurers paying $150 million[4] in benefits for second-tier[5] funded separations in the 2019-20 financial year (FY20).

Default benefits provide most support to consumers in accessing services at new hospitals while those hospitals are in the process of negotiating contracts with insurers. Our analysis found that half of new hospitals have contracts with less than 30% of insurers, whereas half of established hospitals have contracts with more than 95% of insurers,[6] pointing to the higher level of support and funding via default benefits in newer hospitals. Through this function, default benefits increase consumer choice by supporting market entry for new hospitals that may also provide innovative and efficient services.

The safeguarding of consumer access and choice is especially important in regional areas of Australia where there are fewer private hospitals. A halt in services at one hospital could lead to relatively larger adverse effects on the accessibility for consumers in these areas. The safety net function of default benefits supports the equitable access to private hospital services by preventing reduced accessibility for regional consumers in the case that contracts cannot be agreed.

Although the current utilisation of default benefits has been relatively low, with the value of second-tier default benefits only making up 1%[7] of all insurer benefits paid in FY20, there is a significant possibility that they will be utilised more often as the current inflationary environment leads to more protracted and potentially disputed contract negotiations. As contract negotiations across the private healthcare sector are ongoing, default benefits are currently serving an important purpose as a safety net to protect PHI consumers should contracts not be renewed.

In the absence of default benefits, consumers seeking a private hospital service may be limited to only those hospitals within their insurer's contracted network or face substantial hospital out-of-pocket costs to cover the total charge of an admission,[8] diminishing their access to, and choice between, services, potentially resulting in consumers choosing not to receive the required health service in a private hospital, or at all.

Other purposes of default benefits

There were no apparent issues with default benefits fulfilling their other purposes. However, the broader purpose of allowing PHI policies to only offer restricted cover for certain service types and meet product classification criteria should be considered, however is outside the scope of this study. The low level of cover that these policies offer for these services may lead to significant hospital out-of-pocket costs for consumers.

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[4] This value was calculated as the sum of hospital benefits and medical benefits (excluding Medicare benefits) for separations that were flagged as being funded by second-tier default benefits. The data source is pre-processed HCP1 data supplied by the Department. For medical benefits, only the benefits paid for separations with a valid medical record were included in the calculation. 68% of second-tier funded separations in FY20 had a valid medical record.

[5] Refer to Section 1.4 for default benefits, minimum benefits and second-tier default benefits definitions

[6] These values were calculated through analysis of the data.gov.au Agreement Hospitals matrix as at 1 August 2022 and hospital data held by the Department. A hospital was defined as new if its opening date was in 2016 or later. These values are sensitive to this definition and the underlying data.

[7] This value was calculated by dividing the $150 million quoted above by the equivalent calculation for all separations, regardless of the funding arrangement of the separation. For medical benefits, only the benefits paid for separations with a valid medical record were included in the calculation. Overall, 80% of separations in FY20 had a valid medical record.

[8] Consumers could also switch insurers and/or seek alternative treatment pathways, such as through the public healthcare system. However, there are potential practical and health outcome consequences of each of these opportunities, adding to the importance of default benefits.

Negative impacts: issues arising from default benefits

We have identified four key issues with the current default benefit arrangements:

- Due to the design of the mechanics that determine the second-tier default benefits, insurers are able to potentially manipulate the rates downwards by including low rates for services in contracts with hospitals that do not provide that service. This may lead to private hospital under-funding and/or consumers paying additional out-of-pocket costs.

- There is currently no limit on the level of hospital out-of-pocket costs that can be charged to patients when their separation is funded by default benefits, whereas contracts usually do not allow for any out-of-pocket costs. Although some level of out-of-pocket costs may be required to cover costs under default benefits, the lack of a limit leaves consumers exposed to the risk of potentially significant out-of-pocket costs. The hospital's perspectives of its requirements needs to be balanced against the consumers' needs and whether it is reasonable for a hospital to charge the consumer potentially high and unregulated hospital out-of-pocket costs in a situation where it has received regulated benefit amounts.

- Aspects of the current arrangements, particularly the wide ranges of second-tier default benefit rates and schedule structures, are inefficient and contribute towards administrative burden for both hospitals and insurers. Ultimately these costs flow to higher out-of-pocket costs and/or higher PHI premiums for consumers.

- Hospital in the home (HITH) is a model of care that can be more cost efficient than in-hospital services, and the option to receive HITH care is valued by consumers. However, it cannot be accessed through default benefits. This leads to inconsistencies in the accessibility of HITH services for patients:

    - In private hospitals, depending on their choice of insurer and level of cover

    - In public hospitals, depending on whether they are admitted as a public patient (where HITH services are funded if delivered in line with each jurisdiction's guidelines) or a private patient funded by minimum benefits.

    These inconsistencies can be confusing for consumers, as well as hospitals and insurers, and can limit consumer access.

No material impact from default benefits

Some stakeholders have suggested that default benefits are having negative consequences on aspects of the private healthcare market which ideally would be unaffected by default benefits as they are outside of the intended purpose. However, our assessment found that default benefits do not have a material impact in these areas.

- As noted above, we consider that any observed safety and quality issues relating to default benefit-funded services should not solely be considered as an indication of the ineffectiveness of default benefits. However, adequate hospital funding is required to support the national safety and quality standards and framework.

- Default benefits do not appear to be a significant contributor towards inefficiencies in contracting, given the relatively lower level of second-tier default benefits compared to contracted rates diminishing any "price floor" impact on contracts.

- Some stakeholders have suggested that default benefits are causing an oversupply of services in metropolitan areas through their support of new hospitals. However, our analysis has not found explicit evidence that oversupply is a material problem and second-tier funded services have been decreasing since FY18 in these areas.

1.3 Recommendations: direction for future state

Our recommendations have been developed with regard to prioritising outcomes that will most benefit PHI consumers. Healthcare funding in the private system involves many stakeholders operating under complex regulations and contracting arrangements. Therefore, consideration has been given to the feasibility of transition and implementation of our recommendations and potential impacts on non-consumer stakeholders including hospitals, medical specialists, insurers and government.

Broader areas for potential reform exist across all aspects of the PHI supply chain. The Department is undertaking reforms of the Prostheses List (PL) and Risk Equalisation (RE), and there are synergies and convergence in the potential direction of these reforms with those recommended for default benefits below.

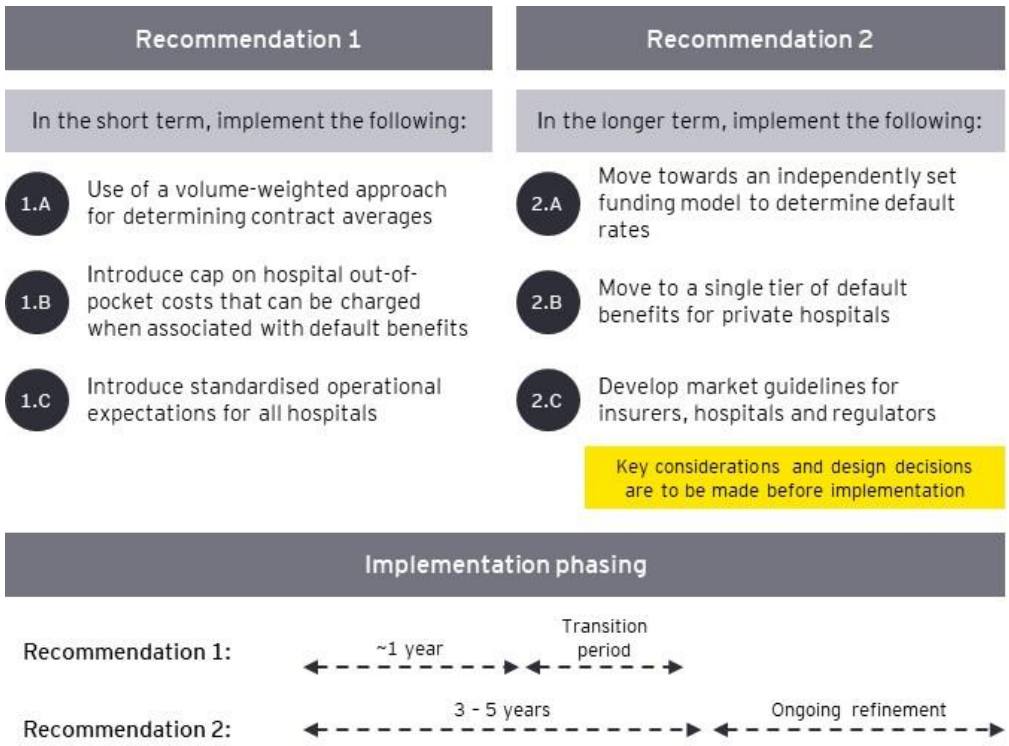
Potential future changes to the private hospital licensing/registration and accreditation processes and PHI product design and classification policies would also interact with the study Recommendations.

Additional process improvements have been identified to improve available data and strengthen cross-industry collaboration to further support the study Recommendations.

We have identified ***two Recommendations*** for the reform of default benefit arrangements, which are described in more detail below. Both of these Recommendations are combinations of separate but related improvement ***Opportunities*** (see Section 4) that should be implemented as bundles for greater synergies and improved outcomes.

The next steps towards implementation for both of these Recommendations could begin in parallel, as shown in Figure 2.

Figure 2: Overview of recommendations



1.3.1 Recommendation 1: short-term reform of default benefits

This Recommendation comprises three Opportunities intended to directly address most of the current issues with default benefits described in Section 1.2.

- **Opportunity 1.A: Use of a volume-weighted approach for determining contract averages**

  Overall objective: To reduce the potential risk of manipulation of second-tier default benefit rates and to align them with actual contract rates paid. This should support sufficient insurer funding to providers so that they are viable without the need to charge excessive hospital out-of-pocket costs, thereby supporting consumer access and choice.

  To support improvements in transparency and consistency around the application of the new formula, consideration could be given to developing specific audit guidelines and a mechanism for enabling the Department direct visibility of underlying calculations.

- **Opportunity 1.B: Introduce a cap on hospital out-of-pocket costs that can be charged when associated with default benefits**

  Overall objective: To protect consumers from the potential for high hospital out-of-pocket costs that could otherwise be charged by some second-tier funded providers. Implementing 1.A above should reduce some of the pressure on second-tier funded providers to charge hospital out-of-pocket costs.

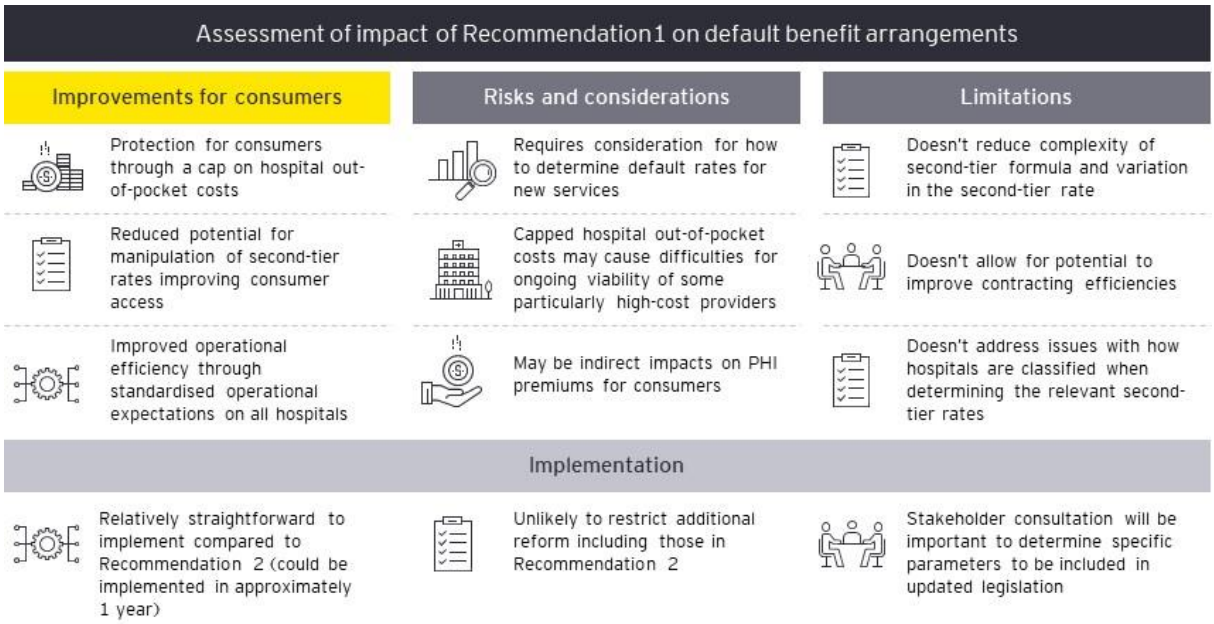
- **Opportunity 1.C: Introduce standardised operational expectations for all hospitals**

  Overall objective: To promote better operational practice expectations (such as mandating the use of national digital health infrastructure, such as Digital Health Records, or participation in nationally recognised clinical registers), reduce inefficient and duplicative contract terms, and to improve the timeliness, quality and consistency of data reporting. These requirements would apply across all private hospitals via the private hospital declaration process, regardless of whether they are funded through default benefits or contracts. This should support a more efficient private healthcare sector, to the ultimate benefit of consumers.

  Note that Opportunity 2.C (below), develop market guidelines for, and in consultation with, insurers, hospitals and regulators, is intended to align with and build upon this Opportunity in order to drive better-practice and support innovation.

Although these components are relatively straightforward to implement, there are a number of design decisions to be made (including updating relevant Commonwealth legislation), which will require stakeholder consultation to optimise.

Figure 3: Assessment of recommendation 1



1.3.2 Recommendation 2: longer-term reform of default benefits

This Recommendation comprises three Opportunities intended to drive further efficiencies (on top of those delivered through Recommendation 1) within default benefit arrangements, as well as potentially enabling benefits for contracted arrangements.

- **Opportunity 2.A: Introduce an independently set funding model**

  This Opportunity involves an alternative approach to determining the default benefit rates. Second-tier default rates (and optionally minimum default benefits) would be determined by an independent body using a funding model to determine a benchmark price alongside weighted activity units for services. This could be similar to the National Efficient Price (NEP) model which underpins activity-based funding for public hospital services.

  Overall objective: To provide consumers with confidence that the safeguard level of default benefits supports adequate funding for safe and quality care. It would achieve this by improving the consistency and robustness of second-tier default benefit rates, reducing inefficiencies associated with wide price variation for similar services, and further reducing the administration costs associated with default benefit rates.

  With sufficient confidence that the default rates provide adequate funding to support the provision of safe and quality care, there should be less need for private hospitals to charge out-of-pocket costs, and so the cap from Opportunity 1.B could be further revised.

  In combination with Opportunity 2.C below, the independently set funding model could be designed to provide a framework for broader insurer funding of care types such as HITH where appropriate.

  The increased transparency of cost data and benchmark pricing for the purpose of determining second-tier default benefit rates could also enable broader efficiency benefits for contracted arrangements. The expectation is for these efficiencies in contracting to flow onto consumers in the form of increased value from their PHI products.

- **Opportunity 2.B: Move to a single tier of default benefits for private hospitals**

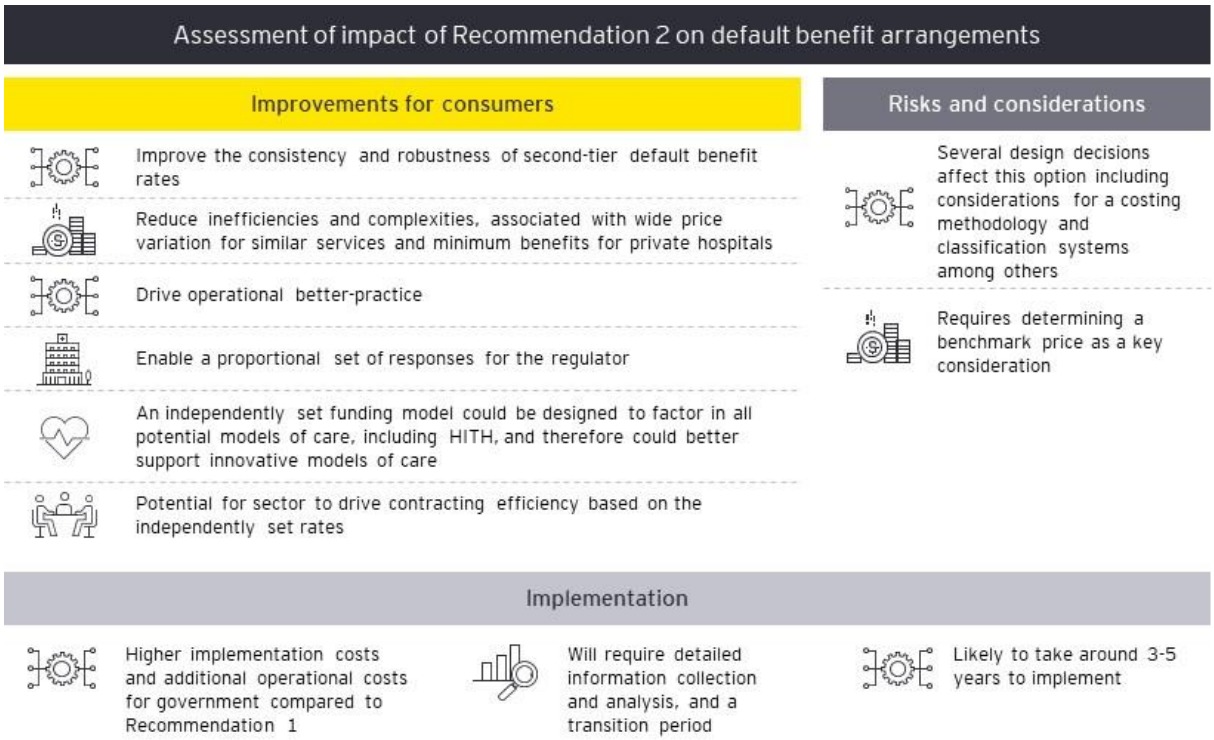
  Overall objective: The intended purposes of minimum benefits are to provide choice to PHI consumers by funding private patients in public hospitals and to protect consumers by providing a level of benefit for private hospital services where their product only offers restricted benefits. This Opportunity intends to retain the same approach for setting minimum benefit rates in alignment with these two intended purposes in the short term with a shift to utilising the independently set funding model for private hospitals when available (Opportunity 2.A), thereby reducing the complexity of the minimum benefits for private hospitals but retaining their purpose for public hospitals.

- **Opportunity 2.C: Develop market guidelines for insurers, hospitals and regulators**

  Overall objective: To further support contracting efficiency (achieved through Opportunity 1.C) by promoting common terminology, definitions and performance measures (for example Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs)), drive operational better-practice beyond standard expectations as described in Opportunity 1.C, drive broader insurer-funding of innovative services such as HITH where appropriate by describing a framework for contract negotiations, promote fair and competitive contracting behaviour on both insurer and hospital sides, and to enable a proportional set of responses for the regulator through appropriate Commonwealth legislation. This would enable faster action to be taken that would overall reduce the number of consumers impacted by potential anti-competitive behaviour.

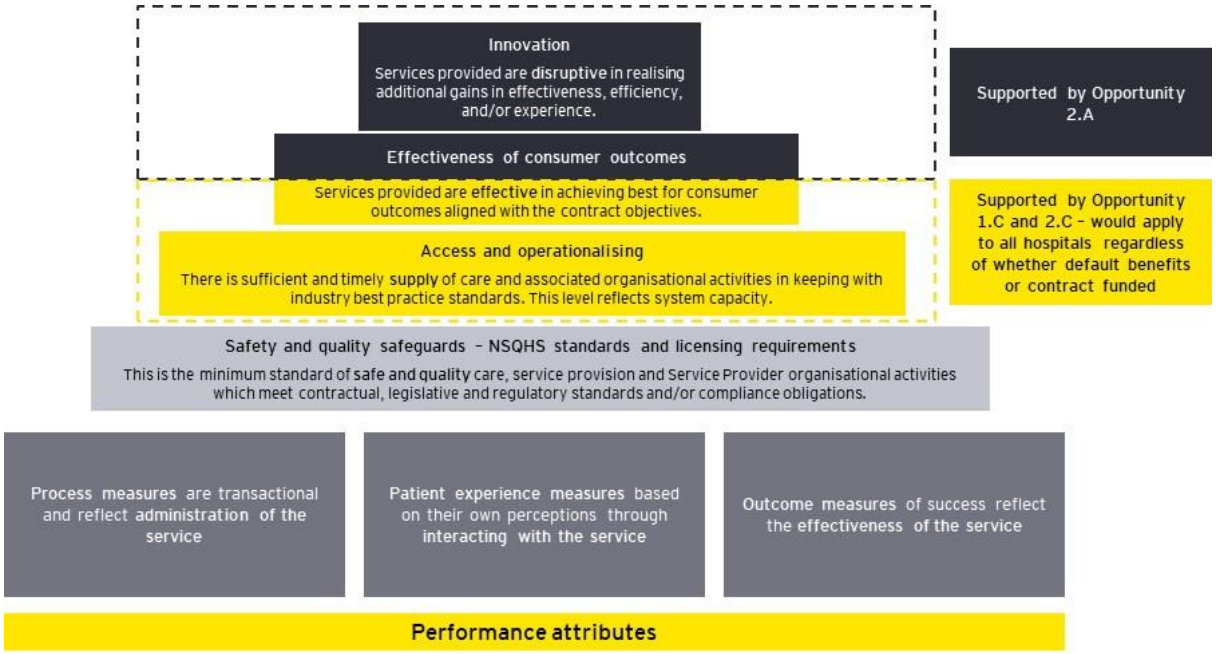
  There are several considerations to work through with stakeholders, including detailed information collection and analysis and a transition period.

Figure 4: Assessment of Recommendation 2



EY has developed a "performance pyramid" describing how different aspects of performance can be achieved when attached to funding mechanisms. Its applicability to future PHI contracting, in particular following the implementation Recommendation 2, is shown in Figure 5.

Figure 5: EY's performance pyramid with applicability to PHI contracting



1.3.3 Additional opportunities for default benefit arrangements reform not recommended at this time

Possibilities for changing the scope of default benefit arrangements that have been considered but are not recommended at this time are as follows:

- **Opportunity 3.A: Limit scope of second-tier default benefits eligibility to certain private hospital types and/or for certain timeframes.** By limiting the scope of and/or imposing time limitations on second-tier default benefits, which some private hospitals are reliant on, this Opportunity may reduce consumer access to and choice of private hospitals. Therefore, at this stage limiting access to default benefit arrangements to certain hospital types or via time limitations is not recommended.

- **Opportunity 3.B: Refine scope of default benefit arrangements to certain service types and new models of care** – with two possible directions:

  - Excluding certain "low value" service types in hospitals – This is not recommended at present as the accreditation and licensing/registration processes are intended to provide consumers with confidence in the safety and quality of all hospital services and private hospitals, and therefore should not be required to be limited by default benefit settings. Furthermore, where default benefit arrangements could better support the efficiency and value of services delivered, this could be more effectively delivered through Recommendations 1 and 2. That there is some evidence that "low value" services have been funded through default benefits suggests a need for improved co-ordination between the different levels of government regulators.

  - Including additional innovative service types such as HITH – While we have identified issues related to the provision and funding of HITH services, as discussed in Section 1.2, these can be better addressed through an independently set funding model and market guidelines for insurers, hospitals and regulators (as noted in the benefits described under Opportunities 2.A and 2.C).

Whilst current arrangements allow for HITH funding through contracting, there are broader considerations to support the availability of these services outside of default benefits funding. In particular, a structured approach is required that considers the types of services that should be accessible for certain conditions, associated safety and quality considerations by the ACSQHC, definitions of services and their scope in relation to an admitted private hospital episode, roles and responsibilities of hospitals, service providers, medical specialists, insurers and regulators, and associated costs.

This structured approach should be considered in developing the independently set funding model (Opportunity 2.A) and in developing appropriate terms and conditions via market guidelines (Opportunity 2.C).

Therefore, after consideration, expanding the scope of default benefit arrangements to include additional innovative service types such as HITH is not recommended in the current settings.

While Opportunity 3.A and 3.B are not currently recommended for the reasons described above, their potential impact could be revisited following the implementation of an independently set funding model described under Recommendation 2.

1.4 Background to this study

In the 2020-21 Budget, the Government announced it would work with consumers, private health insurers, hospitals, and healthcare providers to make PHI simpler and more affordable for Australians. This would be supported through investing in a range of studies into the effectiveness of various regulatory policy mechanisms intended to support the affordability and sustainability of the private healthcare sector.

Default benefits impact payments between insurers and hospital providers and either take the form of minimum or second-tier default benefits.

- Minimum benefit rates are defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* and is the minimum amount that the insurer is required to pay for a hospital admission that is covered by a PHI policy. These benefits are paid if either:
  - There is no negotiated agreement between the hospital and insurer for the specific service(s) that the patient requires and the hospital is not second-tier eligible, or
  - The patient only holds restricted cover for the required service.
- Second-tier default benefits are calculated following the formula set out in *Private Health Insurance (Benefit Requirements) Rules* 2011, which, for each insurer, takes 85 per cent of the average charge for the equivalent episode of hospital treatment under negotiated agreements with comparable private hospitals in the state in which the second-tier eligible hospital is located. These benefits are paid if:
  - There is no negotiated agreement between the hospital and insurer for the specific service(s) that the patient requires, and
  - The hospital is second-tier eligible.

This study assesses the effectiveness of the current default benefit arrangements, identifies opportunities for change to address issues in the current arrangements and puts forward recommendations on the implementation of these opportunities for reform.

Our findings have been informed by a combination of:

- **Extensive stakeholder consultation:** with stakeholders representing the different levels of government, private hospitals, private health insurers, peak bodies, medical professionals and consumers, and through a variety of forums including workshops, individual discussions and responses to a publicly-released consultation paper.[9]

- **Detailed data analysis:** primarily utilising the Australian Department of Health and Aged Care's (the Department) Hospital Casemix Protocol 1 (HCP1), Hospital Casemix Protocol 2 (HCP2) and Private Hospital Data Bureau (PHDB) datasets.

- **Literature review and research**: including previous reviews relating to default benefit arrangements, the legislation that supports the arrangements and private hospital contracting approaches in other countries.

This report presents EY's findings from the study. It is structured in the following way:

- Section 2 provides an overview of the study, including background to the study, objectives, scope and methods used to inform the report.

- Section 3 applies the assessment criteria to the current default benefit arrangements. In doing so, we apply a combination of data analysis as well as drawing upon stakeholder feedback.

- Section 4 introduces opportunities for change that could address some of the issues identified in Section 3. In each case, we assess how the Opportunity could improve outcomes using the assessment criteria and discuss some of the key risks and implementation considerations.

- Section 5 provides a way forward for reforming default benefits that brings together the specific opportunities from Section 4 to form our recommendations, whilst also considering underlying process improvements and interactions with broader reforms to PHI.

[9] Department of Health and Aged Care, 2022. Consultation Paper on Private Health Insurance (PHI) Default Benefit Arrangements. Available at: www.consultations.health.gov.au/medical-benefits-division/consultation-paper-private-health-insurance-defaul/

2. Introduction

This Section provides an overview of the study, including background to the study, objectives, scope, and methods used to inform the report.

2.1 The importance of private health insurance within the healthcare system

2.1.1 Australia's healthcare system

There are currently several major Government health strategies being implemented and promoted, which influence and shape the priorities of the Australian healthcare system. The Government announced Australia's Long Term National Health Plan[10] in 2019, which focuses on making the healthcare system better at preventing disease and promoting health, more focused on patients' multidisciplinary needs, and more affordable and accessible for all Australians. This includes a key pillar of supporting public and private hospitals through the implementation of the National Health Reform Agreement (NHRA), PHI reforms and investments in health innovation and treatment projects across the nation. There has also been an added focus on disease prevention through the National Preventive Health Strategy,[11] aiming to keep people healthy and well by making changes to the health system overall.

Digital health has been a Government priority in the past few years, with the introduction of the National Digital Health Strategy[12] in 2018 to evolve Australia's digital health capability and facilitate digital health integration into the health system through platforms such as My Health Record. Modernising the healthcare system is also a priority of the Long Term National Health Plan and is being achieved through investment in digital health, as outlined in the 2022-23 Budget,[13] to drive improvements in healthcare delivery, access and efficiency.

Another key focus has been person-centred care, due to its impact on improving the safety, quality and cost-effectiveness of healthcare, as well as patient and staff satisfaction.[14] Person-centred care is embedded throughout all Standards developed by the ACSQHC. Further, the National Clinical Quality Registry and Virtual Registry Strategy[15] aims to drive continuous improvements in the value and quality of patient-centred healthcare through better collection, monitoring and reporting of national clinical quality outcomes data and embedding prioritised datasets into Australia's health information systems.

[10] Department of Health and Aged Care, 2019. Australia's Long Term National Health Plan. Available at: www.health.gov.au/resources/publications/australias-long-term-national-health-plan

[11] Department of Health and Aged Care, 2021. National Preventive Health Strategy 2021-2030. Available at: www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030

[12] Digitalhealth.gov.au, 2018. National Digital Health Strategy and Framework for Action. Available at: www.digitalhealth.gov.au/about-us/strategies-and-plans/national-digital-health-strategy-and-framework-for-action

[13] Department of Health and Aged Care, 2022. How the 2022-23 Budget is investing in digital health – Budget 2022-23 fact sheet. Available at: www.health.gov.au/sites/default/files/documents/2022/03/budget-2022-23-investing-in-digital-health.pdf

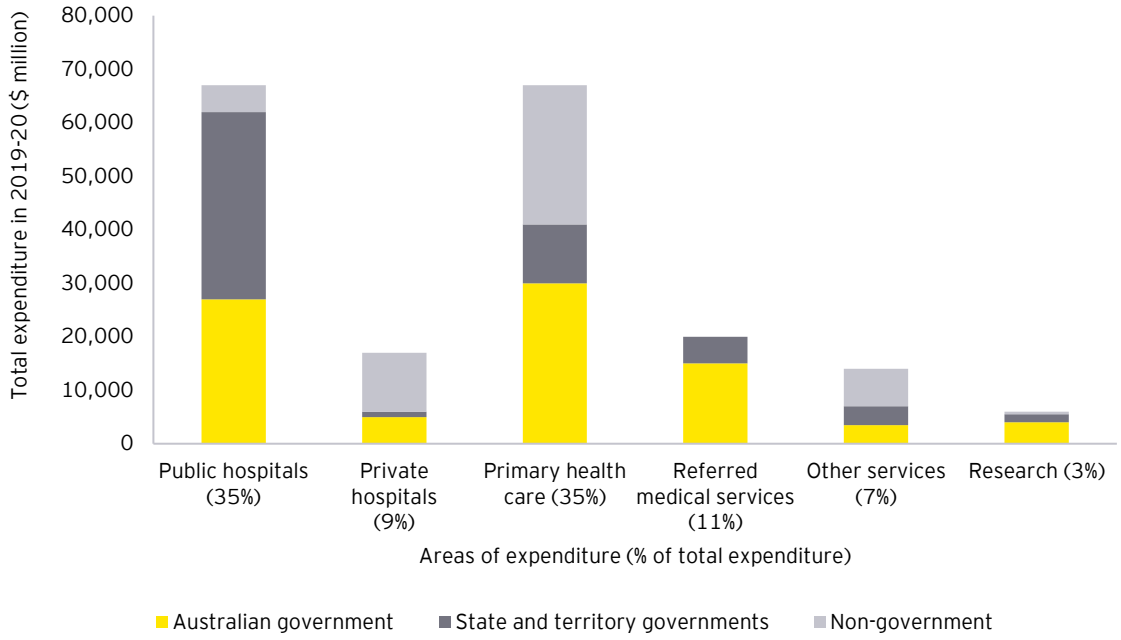
[14] Australian Commission on Safety and Quality in Health Care. Person-centred care. Available at: www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care

[15] Department of Health and Aged Care, 2021. National Clinical Quality Registry and Virtual Registry Strategy 2020-2030. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/national_clinical_quality_registry_and_virtual_registry_strategy_2020-2030

2.1.2 Funding in Australia's healthcare system

Australia's healthcare system is a public and private hybrid, with different parts of the system funded to different degrees by private health insurers, federal and state governments, and individual (out-of-pocket) contributions. Figure 6 below summarises the relative size of expenditure in hospitals, primary healthcare and other services, and the sources of funding for each of these services.

Figure 6: Area of spending by source of funds, 2019-20



***Data source**: Australian Institute of Health and Welfare 2022*[16]

Through Medicare and the Commonwealth/State health funding agreements, the Government is primarily responsible for funding services to support universal access to healthcare. Medicare includes the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS), with the Government also funding the PHI rebate.

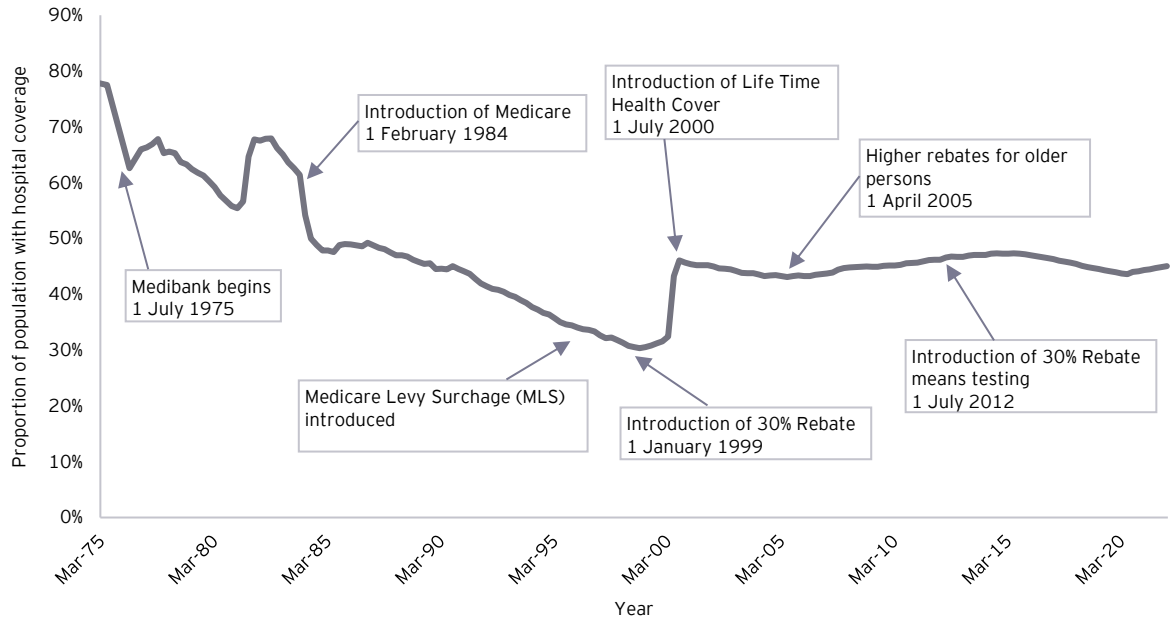
The private sector also provides a broad range of healthcare services and facilities, including private medical practitioners, pathology and diagnostic services, pharmacies, and private hospitals. Private health insurers and individuals (through out-of-pocket costs in addition to the insurer benefits) predominantly fund specialist treatments and associated accommodation costs – but do not fund costs relating to the General Practitioner (GP) referral and consultations and assessments with the specialist prior to treatment. Even in the private sector, medications, and medical services (referred and non-referred) are predominantly funded through the MBS and PBS.

An important consequence of a sustainable private healthcare sector is that it does not put undue pressure onto the public healthcare sector. This is only achieved if PHI is able to offer good value products to consumers that are affordable and support genuine access to, and choice between, services that will deliver the healthcare outcomes that they need.

PHI participation rates give an indication of whether this is occurring. Approximately 45% of Australians currently hold PHI hospital cover, as shown in Figure 7 below.

[16] Australian Institute of Health and Welfare, 2022. Health expenditure. Available at: www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure

Figure 7: Proportion of the Australian population with a PHI hospital product



***Data source**: APRA Statistics Private Health Insurance Membership Trends. March 2022 (released 25 May 2022)*

PHI provides millions of Australians with choice and access to private healthcare services, particularly planned, elective, and non-emergency services. 80% of the 4.4 million separations in private hospitals were privately insured in FY20.[17]

2.2 The need for regulatory reform in private health insurance

Between 2007 and 2021, PHI premiums increased by 4.9%[18] per annum, while the Average Weekly Earnings (AWE) index increased by 3.0%[19] annually. Recent premium increases have been lower than the long-term average (2.74% in April 2021 and 2.70% in April 2022 on average) and there has been recent high Consumer Price Index (CPI) inflation. However, with an ageing population and improved health technology, under current settings PHI claims costs are expected to continue to increase faster than increases in the CPI and AWE in aggregate over the next 10 years and most of this cost would likely be passed onto consumers of PHI through increases to premiums, which may place the sustainability of PHI at risk.

In the 2020-21 Budget, the Government announced it would work with consumers, private health insurers, hospitals, and healthcare providers to make PHI simpler and more affordable for Australians. This would be supported through investing in a range of studies into the effectiveness of various regulatory policy mechanisms intended to support the affordability and sustainability of the private healthcare sector. These studies include the Prostheses List (PL) reforms and studies of Lifetime Health Cover (LHC) and Risk Equalisation (RE). The default benefit arrangements are primarily aimed at ensuring PHI consumers have access to and choice between appropriate private hospital services when needed by ensuring some level of insurer funding in cases where a contract has not been agreed upon between the parties.

[17] Australian Institute of Health and Welfare. Admitted patient care 2020-21 7 Costs and funding. Available at: www.aihw.gov.au/getmedia/4738ebe4-df95-4816-a9d3-19c96a99213c/7-admitted-patient-care-2020-21-tables-costs-and-funding.xlsx.aspx

[18] Department of Health and Aged Care. 2022. Average annual price changes in private health insurance premiums. Available at: www.health.gov.au/resources/publications/average-annual-price-changes-in-private-health-insurance-premiums

[19] Australian Bureau of Statistics. 2022. Average Weekly Earnings, Australia. Available at: www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia/latest-release

2.3 Background to the minimum and second-tier default benefit arrangements

Note on terminology

As described in the following Sections below, there are two types of "default benefits": minimum benefits and second-tier default benefits.

In this report, the term "default benefits" refers to the schedules of rates under minimum benefits and second-tier default benefits. The term "default benefit arrangements" also refers to minimum benefits and second-tier default benefits but captures all associated rules, such as eligibility and the calculation process, as well as the schedules of rates.

Therefore, unless stated otherwise, default benefits and default benefit arrangements can apply to both the public hospital system (through minimum benefits) and the private hospital system (through both minimum benefits and second-tier default benefits).

2.3.1 Purpose of default benefits

Main purpose[20] of default benefits

The main purpose of default benefits[21] is to safeguard private health insurance (PHI) policyholders' access to, and choice between, private hospitals for private health insurance-funded services.

In doing so, default benefits aim to promote equity between consumers by providing a guaranteed level of financial support for hospital treatment, whilst allowing insurers to provide a level of differentiation between private hospitals via contracting.

Default benefits have been designed with the intention of meeting this purpose by ensuring a legislated level of private health insurer (insurer) funding to hospitals in cases where a contract has not been agreed upon between the hospital and the consumer's insurer.

Although there is general consensus in the main purpose, the need for, and design of, the legislated level of insurer funding is highly contentious.

The need for legislative intervention in establishing default benefits arises from the risks that, in their absence:

- Consumer choice might be limited if some private hospitals are unable to agree contracts with insurers
- Consumers may face large hospital out-of-pocket costs in order to access the healthcare services required to meet their health needs, and/or
- Consumers may choose to forego private health services potentially compromising their health outcomes or impacting on the public healthcare system.

[20] Although there is no explicit stated purpose to default benefits in Private Health Insurance (PHI) legislation, we have inferred their main purpose from their design and through stakeholder consultation.

[21] Default benefits refer to minimum benefits and second-tier benefits. Minimum benefits are an amount the insurer is required to pay for a hospital admission that is covered on a PHI policy. Second-tier benefits are a benefit amount paid to second-tier eligible hospitals where a contractual agreement between the insurer and hospital is not in place.

Other purposes of default benefits

Default benefits, specifically minimum benefits, also have two other purposes in providing a funding mechanism to support two other policy areas:

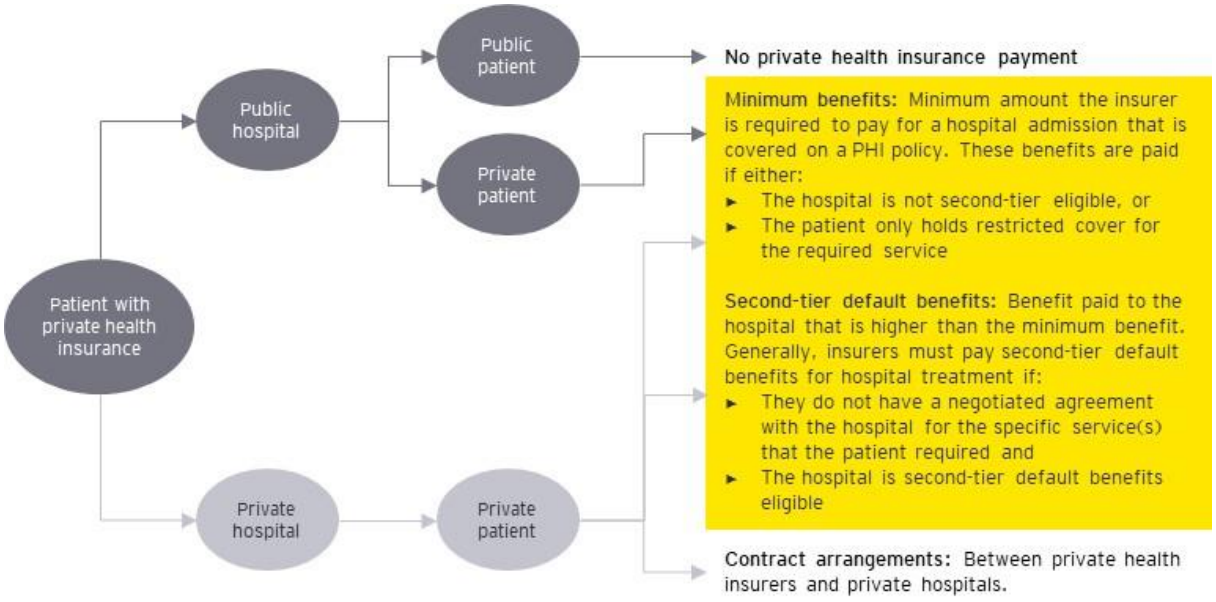
- Private patients in public hospitals, and
- PHI product design – especially where the consumer's product offers "restricted" coverage for certain service types.[22]

These uses differ from the main purpose as, in these settings, minimum benefits are not an alternative to contracting but are the only mechanism through which insurers fund these services.

2.3.2 Overview of default benefits

The amount payable by private health insurers to private hospitals for services is usually defined by a contract between the health insurer and the private hospital. Default benefit arrangements enable payments to be made by insurers to hospitals where there is not an existing contract: they either take the form of minimum benefits or second-tier default benefits. This is detailed in Figure 8 below.[23]

Figure 8: Key hospital[24] funding pathways for patients with PHI, by hospital type



PHI hospital products must provide funding towards any treatment covered under the policy where a Medicare benefit is payable and where the treatment is provided by a hospital or provided or arranged with direct involvement of the hospital (excluding treatment provided in the emergency department of a hospital). Additionally, all hospital products must provide funding of at least the minimum benefit towards psychiatric care, rehabilitation, or palliative care where no Medicare benefit is payable if the treatment is provided in a hospital.

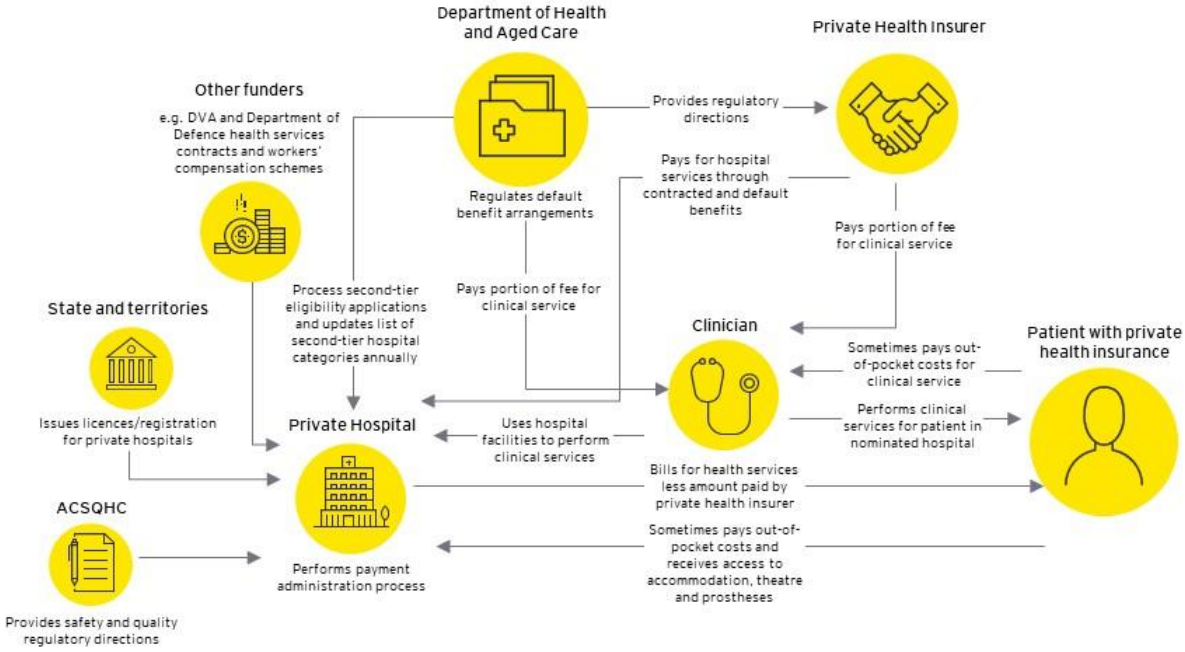
[22] Restricted benefits are where a hospital and insurer have a contractual agreement but the PHI product the consumer holds does not offer coverage for a required service type, for example rehabilitation or mental health services.

[23] This diagram represents the key funding pathways for patients with private health insurance. The data we received from the Department contained a small volume of public hospital separations that were flagged as second-tier funded or contracted. However, this is expected to be data errors and, for the purpose of this study, we have recoded these separations as "not contracted", that is, funded by minimum benefits.

[24] Other funding pathways occur for medical and prostheses costs.

Figure 9[25] below details the various flows of services within the private hospital system and funding of minimum and second-tier default benefits and the role each stakeholder plays in their function.

Figure 9: Overview of the provision of private hospital services and funding to patients with PHI



There are three high-level aspects to the default benefit arrangements:

- The **format of the rates** – i.e. how the default benefits are determined
- The **associated rules relating to default benefits** intended to support their operation in the marketplace
- The **scope of default benefits** – i.e. the types of hospitals and services that might attract default benefit funding.

The specific design of the current minimum and second-tier default benefit arrangements, and a comparison of the settings under contracted arrangements, is shown below in Table 1.

Table 1: Key characteristics of minimum and second-tier default benefits and contracted benefits

Aspect	Key characteristic	Minimum benefits	Second-tier default benefits	Contracted agreement
Format of rates	**Benefit determination**	Minimum amount defined in legislation	85% of average charge for equivalent episode of hospital treatment (refer to Section 2.3.4.1 for details)	Privately negotiated contracted agreements that are commercial-in-confidence and not disclosed to the Department
	Benefit amount	Lowest	Higher than minimum but generally less than contracted benefits	Generally highest

[25] To support the interpretation of this figure, minimum benefits paid to private patients in the public hospital system are not included.

Aspect	Key characteristic	Minimum benefits	Second-tier default benefits	Contracted agreement
	Rate schedule structure	By procedure type26 (Types A, B and C – see Section 2.3.3). Covers accommodation through per diem rates	A mix of case payments/diagnosis-related group (DRG) and per diem. It is also separated by state and hospital category	Individual agreements between PHIs and private hospitals
Associated rules	**Transparency of rates**	Published in the legislation	Second-tier schedules do not have any publishing requirements	Commercial-in-confidence agreements between insurer and hospital
	Relation to hospital out-of-pocket costs	No legislated rules around hospital out-of-pocket costs where minimum benefits are paid	No rules on hospital out-of-pocket costs associated with second-tier default benefits	Contracts will often preclude or cap the possibility of out-of-pocket costs
	Requirements on hospitals	Hospitals must apply, and meet legislated requirements including state and territory licensing/registration and national safety and quality accreditation requirements	Private hospital must apply and eligibility is reviewed typically every three years. The second-tier eligibility period is aligned to national hospital accreditation cycles and requirements. (refer to Section 2.3.4.2 for eligibility requirements)	Must meet state and territory licensing/registration and national accreditation requirements. Additional KPIs vary from contract-to-contract
Scope of benefits	**Scope of hospitals**	In-hospital services at public or private hospitals	In-hospital services at private hospitals	Any provider of hospital or hospital-substitute treatment
	Scope of charges	Covers hospital accommodation only	Covers hospital benefits, excluding prostheses	Covers hospital benefits. Insurers generally have separate agreements with practitioners for the medical benefits and these agreements are not a component of PHI regulatory arrangements.

Service utilisation trends for privately insured patients across the different contracting arrangements is shown in Figure 10 and Figure 11.

Interpreting the study graphs

In interpreting the graphs based on HCP data within this report, the reader should be aware of some key data quality limitations. Data on the funding arrangements are reliant on the *hospital contract status* variable within the private health data collections, which identifies the payment arrangement the insurer has with the hospital, primarily consisting of the following:[27]

- **Contract** - a hospital with which an insurer has a contract
- **Not contracted** - a hospital with which the insurer does not have a contract
- **Second-tier** - a private hospital is paid under second-tier default benefit arrangement

[26] Department of Health and Aged Care. 2022, Type C hospital certification. Available at: www.health.gov.au/topics/private-health-insurance/private-health-insurance-reforms/type-c-hospital-certification

[27] The variable definition and descriptions are taken verbatim from the HCP1 data specifications. There are also a small number coded to B – "a hospital is paid under a "Bulk payment" arrangement".
Department of Health and Aged Care. 2022. HCP1 – Insurer to Department data specifications 2022-23 – effective 1 July 2022. Available at: www.health.gov.au/resources/publications/hcp-data-specifications-hcp1-insurer-to-department-2022-23

The generally agreed interpretation of the *hospital contract status* variable is that it reflects whether there is a contract in place between the relevant hospital and insurer, and does not provide information about the contracting arrangement at a separation-level. Specifically, even if a hospital and insurer have a contract, there are some types of separations or procedures that may not be covered under that contract. These separations would be flagged as "contract" but may be funded by second-tier default or minimum benefits.

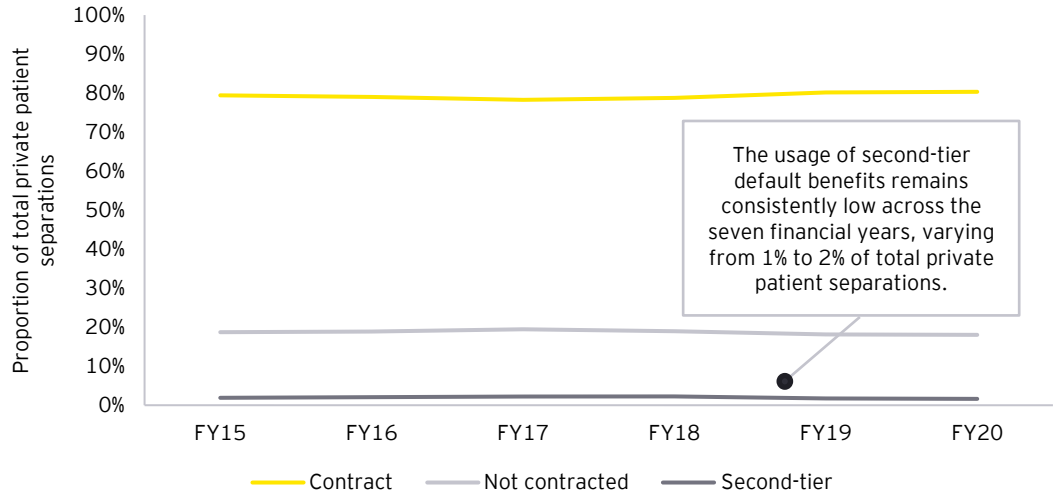
The graphs based on HCP data only include trends up to and including FY20 to minimise the inclusion of any COVID-19 impacts on the trends presented.

Analysis of funding arrangements for privately insured patients

The usage of different funding arrangements for admitted private patients can be understood through trends within the HCP1 data source.

Figure 10 presents the proportion of private patient separations in each financial year that are funded by contracts, second-tier default benefits or are not contracted.[28] More than 95% of "not contracted" separations occur in public hospitals and can be interpreted as being funded by minimum benefits. Averaged over the six financial years, 2% of all private patient separations were funded by second-tier default benefits. Across FY15 to FY20, the split between contract status remains relatively stable, with approximately 80% of private patient separations funded by contract arrangements between the hospital and the private health insurer.

Figure 10: Proportion of hospital separations funded by each contract status per financial year



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

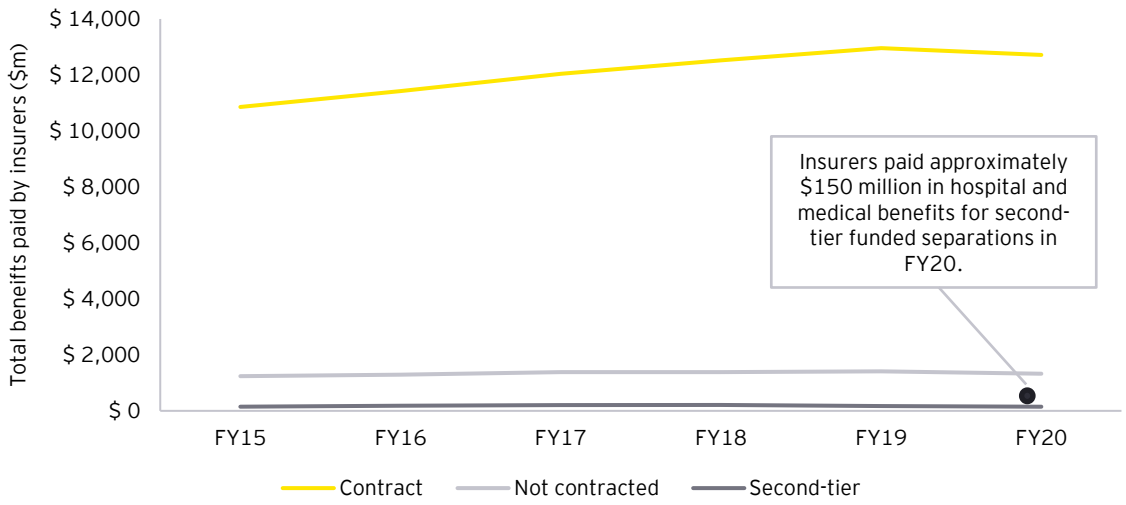
- *Within the hospital contract status variable, there are a number of separations that are under a "bulk payment" arrangement or have a blank hospital contract status. Whilst the trends for these separations are not shown explicitly within this chart, these separations were factored into the calculation of proportions. As such, the proportions in this chart do not add to 100%.*

This can be viewed in conjunction with the total insurer funded benefits for separations under the different funding arrangements as presented in Figure 11. In FY20, the total hospital and

[28] Due to the data quality issues in the hospital contract status flag, caution should be taken when interpreting the "not contracted" trend. Refer to Section 2.3 for details.

medical benefits paid by insurers for second-tier funded separations was approximately $150 million,[29] which constituted 1% of all insurer paid hospital and medical benefits.

Figure 11: Total benefits paid by insurers for each contract status and financial year



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The benefit types within the HCP1 data are: hospital benefits, Medicare benefits and insurer benefits (medical). The chart above captures hospital benefits and insurer benefits (medical) only.*
- *For medical benefits, only separations with a valid medical record are included in this calculation. Around 20% of all separations did not have a valid medical record and thus, the actual total benefits paid by insurers are likely to be higher than the values in this chart.*

The following sections (Section 2.3.3 and 0) describe minimum and second-tier default benefits in more detail.

2.3.3 Minimum benefits

The minimum benefit is the minimum amount the insurer is permitted to pay for a hospital admission that is covered under a PHI policy.[30] The minimum benefits are set by the Government as outlined in the *Private Health Insurance (Benefit Requirements) Rules 2011*. These depend on the MBS items for the procedure performed or services provided. The rules, sourced from the Department website, define these procedures by grouping MBS items into:[31]

- **Type A procedures** – usually done in hospital, with part of an overnight stay (higher accommodation benefits)
- **Type B procedures** – usually done in hospital, without part of an overnight stay (lower accommodation benefits)
- **Type C procedures** – do not normally need hospital treatment or accommodation (no accommodation benefits)

At least the minimum benefit amount must also be paid for any part of hospital treatment that is psychiatric care, rehabilitation or palliative care if the treatment is provided in a hospital and no

[29] This value is represented by the FY20 value on the teal line in Figure 11. Please see the interpretation, limits and cautions accompanying the figure.

[30] Private health.gov.au. Glossary. Available at: www.privatehealth.gov.au/footer/glossary.htm

[31] Department of Health and Aged Care. 2022, Type C hospital certification. Available at: www.health.gov.au/topics/private-health-insurance/private-health-insurance-reforms/type-c-hospital-certification

Medicare benefit is payable for that part of the treatment.[32] This results in minimum benefits being payable for psychiatric care, rehabilitation or palliative care in the situation where the consumer's PHI policy has only restricted coverage for those hospital services.

The minimum benefit is paid when:

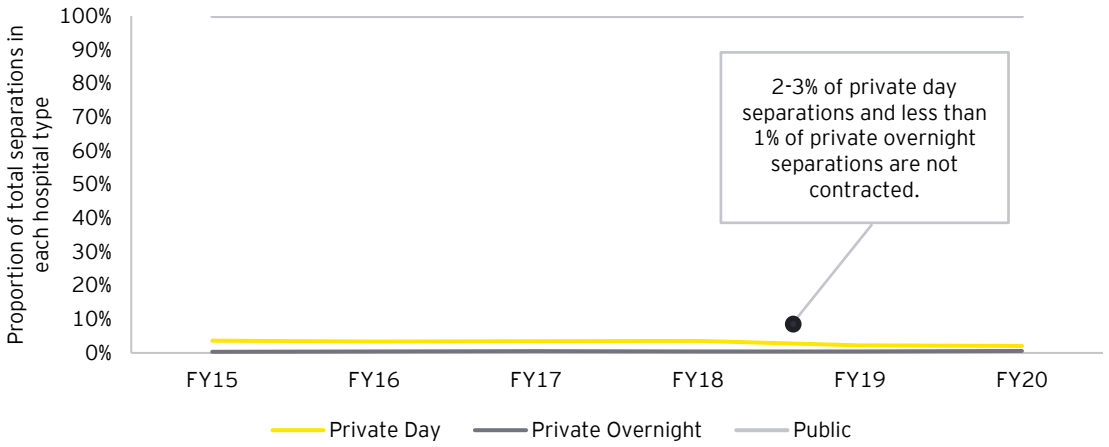
- The hospital does not have a negotiated contractual agreement with the consumer's private health insurer for the required service and the hospital is not second-tier eligible, or
- The consumer's PHI policy only has restricted coverage for the required service.

Analysis of payments through minimum benefits

Figure 12 shows the proportion of all private patient separations in public and private hospitals that were not contracted. These separations within public hospitals can be interpreted as being funded by minimum benefits. However, there are data quality issues with private hospital separations that are flagged as "not contracted", and it is unclear whether these separations are funded as a minimum, second-tier default or contracted benefit. Recommendations for data improvements to address this issue are presented in Section 5.2.1.

This figure shows that private hospitals are not contracted for a small proportion of separations, whereas all public hospital separations are not contracted and funded through minimum benefits.

Figure 12: Proportion of all separations in each hospital type that are not contracted



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *This graph represents the proportion of private patient separations in each hospital type and financial year, that are not contracted.*
- *A small proportion of public hospital separations were originally flagged as second-tier funded or contracted. The Department conducted an investigation on this and advised us to flag all public hospital separations as not contracted.*
- *The identification of hospital type is based on the "Declared information management system hospital type" flag within the HCP1 data. Private overnight hospitals refer to those with a hospital type of "private other".*

2.3.4 Second-tier default benefits

Generally, a patient's private health insurer must pay second-tier default benefits for hospital treatments if the insurer does not have a negotiated contractual agreement with the private hospital and that the private hospital is "second-tier default benefits eligible".

[32] Outlined in subsection 72-1(2) of the PHI Act

Second-tier default benefits were introduced in 1998 when the PHI industry was reacting to legislation changes that allowed contracting between private health insurers and private hospitals. Participation in PHI was around 30% (see Figure 7) and there was concern about the viability of private hospital facilities and their ability to secure funding through the contracting process. The Government introduced second-tier default benefits as a mechanism to support the viability of private hospital facilities and, in doing so, to improve choice and access for consumers.

In 2003, the Government proposed to remove second-tier default benefits. This did not occur as it was argued that its removal would reduce the number of hospital providers for different services, creating a disadvantage of reduced choice for PHI consumers, particularly those in rural, remote, and regional areas.[33] As noted in Section 2.3.1, without second-tier default benefits, hospitals would receive minimum benefits, which, in most cases, would be a substantially lower amount.

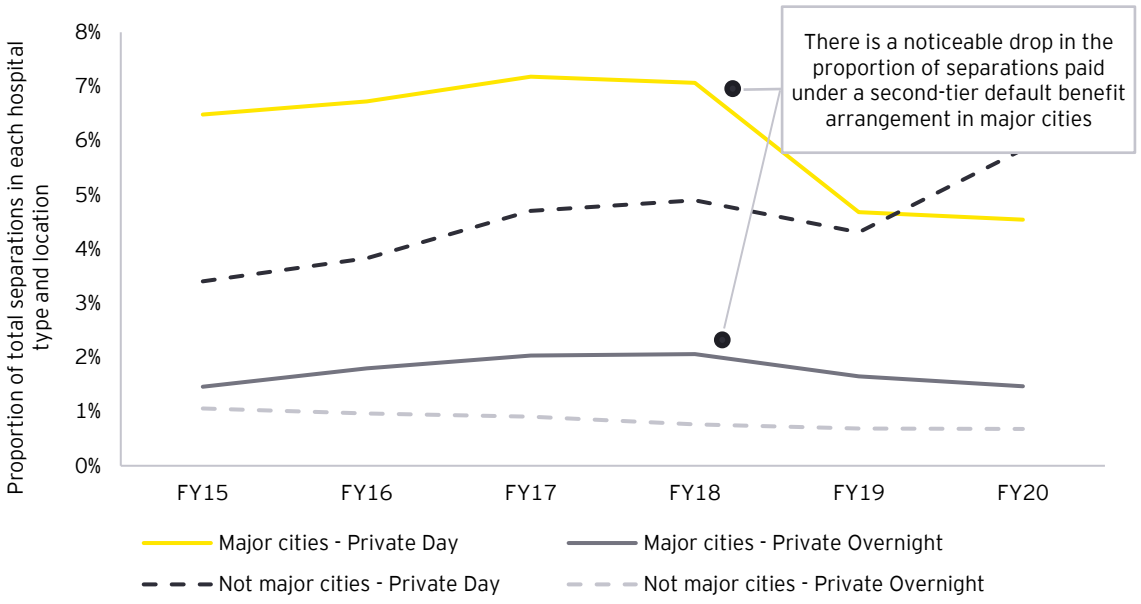
Analysis of payments through second-tier default benefits

Figure 13 and Figure 14 show the proportion and number of private patient separations (respectively) where the hospital was paid under second-tier default benefits by private hospital type and location, for each financial year.

In hospitals located in major cities, there has been a noticeable drop in separations paid under second-tier default benefits from FY18. This trend is particularly noticeable for private day hospitals, with the proportion decreasing from around 7.1% in FY18 to 4.5% in FY20. Private day hospitals appear to use second-tier default benefits more frequently than private overnight hospitals, with an average of 5.8% of separations paid by second-tier default benefits across all private day hospitals across the financial years (regardless of location), compared to an average of 1.6% of separations for all private overnight hospitals.

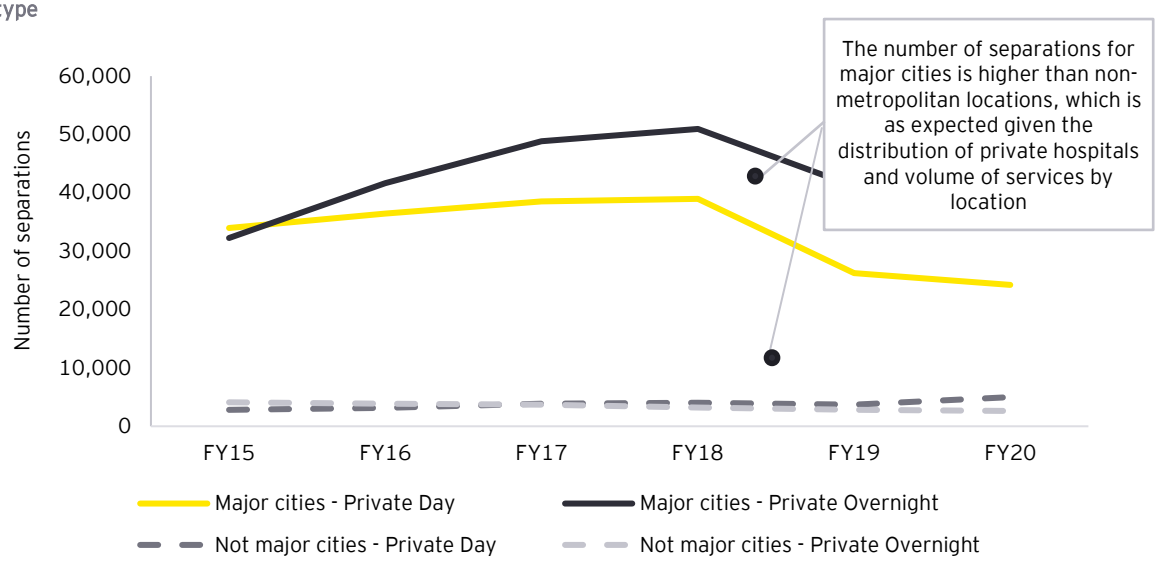
In general, second-tier default benefits are paid more often to hospitals in major cities, than hospitals outside major cities, and to day hospitals, than overnight hospitals.

Figure 13: Proportion of separations paid by second-tier default benefits, by location and hospital type



[33] Private Health Ministerial Advisory Committee. 2016-2017. Issues Paper: Contracting and Default Benefits.

Figure 14: Number of separations where the hospital is paid by second-tier default benefits, by location and hospital type



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *Represents the proportion and number, respectively, of private patient separations where the hospital was paid a second-tier default benefit, by private hospital type and location for each financial year.*
- *For example, in FY20, around 5,000 separations in private day hospitals located in non-major cities were funded by second-tier default benefits and this represents around 6% of total separations in these hospitals. The remainder of the separations are largely funded by contracts.*
- *The identification of hospital type is based on the "Declared information management system hospital type" flag within the HCP1 data. Private overnight hospitals refer to those with a hospital type of "private other".*
- *The hospital location categories were derived from the Modified Monash Model (MMM) categories, where a MM 1 category is major city and MM 2 to 7 were grouped to represent not major cities.*

2.3.4.1 How are second-tier default benefits calculated?

The method for calculating second-tier default benefits is set out in the *Private Health Insurance (Benefit Requirements) Rules 2011*. Second-tier default benefits are calculated as no less than 85 per cent of the average charge for the equivalent episode of hospital treatment under that insurer's negotiated contractual agreements with comparable private hospitals in the state in which the second-tier eligible hospital is located.

Each insurer calculates its second-tier default benefits annually, based on its negotiated contractual agreements in force on 1 August each year and these apply to admissions between 1 September of that year and 31 August the next year. The benefits are calculated as follows:

- The hospitals with which the insurer has negotiated agreements are split into States and Territories. For this calculation, ACT is taken to be part of NSW and the NT is taken to be part of SA.
- These hospitals are then split into the seven categories as specified in the *Private Health Insurance (Benefit Requirements) Rules 2011*. These categories are reviewed and published every year by 1 August by the Department, for all private hospitals. The categories are described in Table 2 below.

Table 2: Categories of private hospitals

Category (as used in this report)	Description
(a) - Psychiatric care hospital	Private hospitals that provide psychiatric care, including treatment of addictions, for at least 50% of the episodes of hospital treatment, and do not fall into category (g)
(b) - Rehabilitation hospital	Private hospitals that provide rehabilitation care for at least 50% of the episodes of hospital treatment, and do not fall into categories (a) or (g)
(c) - Small hospital	Private hospitals that do not fall into categories (a), (b) or (g), with up to and including 50 licensed beds
(d) - Medium size	Private hospitals that do not fall into categories (a), (b) or (g), with more than 50 licensed beds and up to and including 100 licensed beds
(e) - Large – no ICU, cardiac or emergency unit	Private hospitals that do not fall into categories (a), (b) or (g), with more than 100 licensed beds, without an accident and emergency unit or a specialised cardiac care unit or an intensive care unit
(f) - Large – with an emergency, cardiac or ICU unit	Private hospitals that do not fall into categories (a), (b) or (g), with more than 100 licensed beds, with either (or any combination of) an accident and emergency unit or a specialised cardiac care unit or an intensive care unit
(g) – Short-term care	Private hospitals that provide episodes of hospital treatment only for periods of not more than 24 hours

- The relevant "episode of hospital treatment" is identified, with consideration of the patient classification system and payment structure in the majority of the insurer's negotiated agreements with all comparable hospitals in the State.

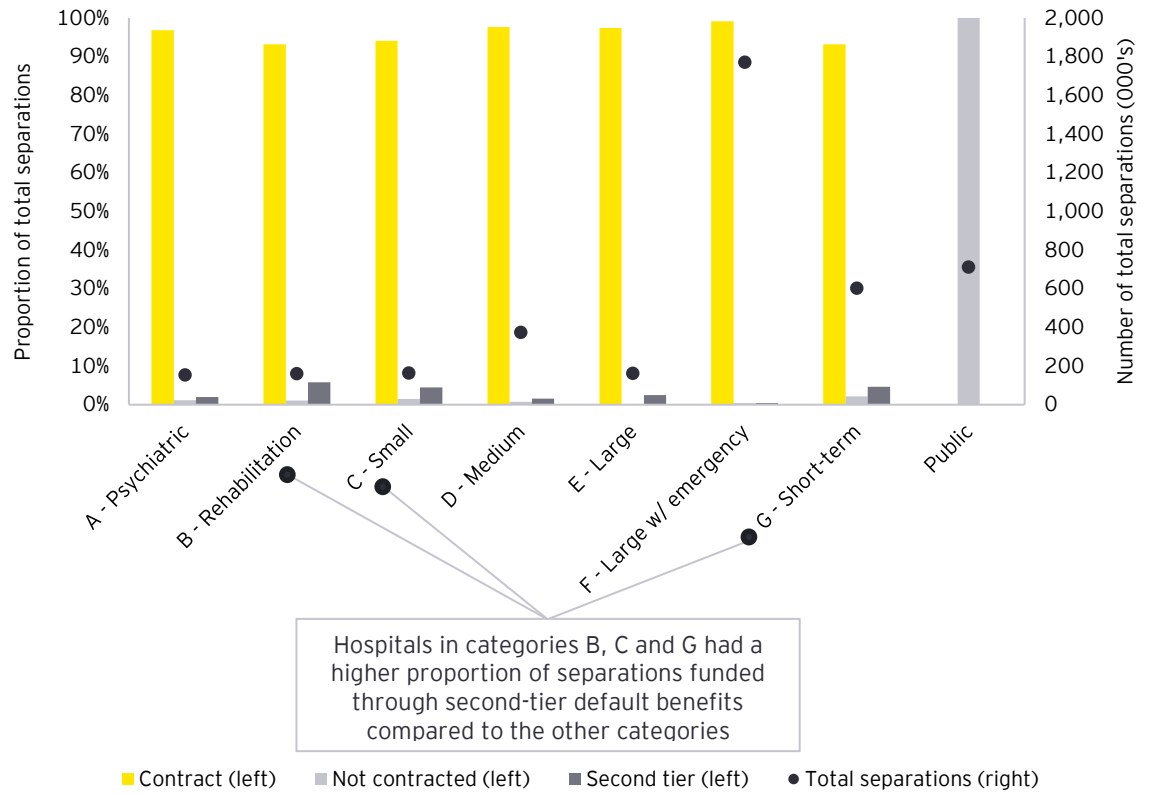
- The rate for each episode of hospital treatment is then calculated as 85% of the average contracted rates within each group of hospitals. The detailed method of calculation is provided in Appendix D.

Analysis of funding arrangements by hospital category

The funding arrangement patterns in FY20 can be disaggregated by hospital category, as shown in Figure 15. This shows the number of private patient separations in each hospital category and the proportion where the hospital was paid by contracted rates, second-tier default benefits or were not contracted.

For private hospitals, hospital categories represent the second-tier categories defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* and public hospitals (P) are categorised separately. Category B, C and G hospitals used second-tier default benefits for a higher proportion of separations than other categories.

Figure 15: Proportion of separations funded by each contract status arrangement in each hospital category in FY20



***Data sources**: Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022), Private hospital second-tier category lists*

Interpretation, limits and cautions:

- *Due to the noted data quality issues in the hospital contract status flag, separations in private hospitals where the hospital contract status is "not contracted" in this graph may actually relate to hospitals that fall under second-tier or are in contracts. Refer to "Interpreting the Outputs" in Section 2.3.2 for details.*
- *Within the hospital contract status variable, there are a number of separations that are under a "bulk payment" arrangement. Whilst the trends for these separations are not shown explicitly within this chart, these separations were factored into the calculation of proportions. As such, the proportions in this chart do not add to 100%.*
- *A small number of separations were at hospitals whose provider ID did not match up with a provider ID in the respective hospital category list and were removed from this analysis.*

Despite the relatively low number of separations funded by second-tier default benefits, a high proportion of hospitals in most hospital categories hold second-tier eligibility as shown in Table 3. A lower proportion of category B, C and G hospitals hold second-tier eligibility. These categories have a higher number of second-tier funded separations as shown in Figure 15.

Table 3: Proportion of private hospitals with second-tier eligibility as at 31 October 2022 by second-tier category

Second-tier category	A - Psychiatric	B - Rehabilitation	C - Small	D - Medium	E - Large	F - Large with emergency	G - Short-term
% with second-tier eligibility	98%	80%	80%	98%	100%	100%	69%

***Data sources**: Private hospital second-tier category list as at 1 August 2022, Commonwealth declared hospitals as at 31 October 2022*

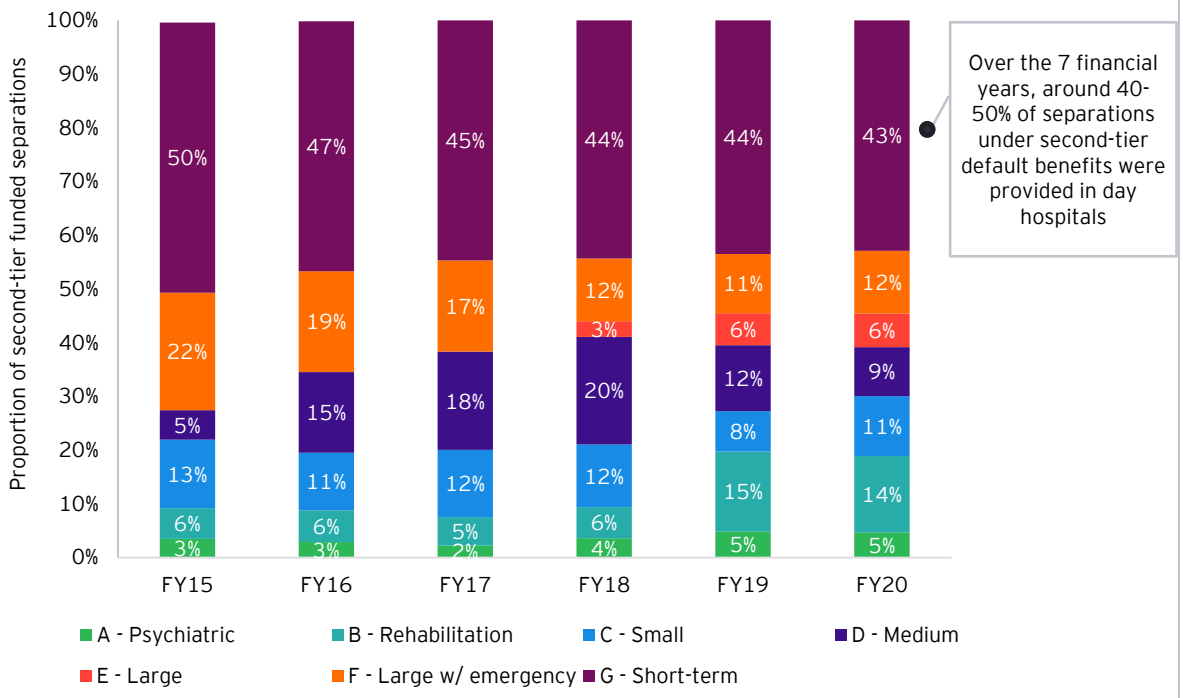
Interpretation, limits and cautions:

- *6 hospitals in the second-tier category list did not appear in the declared hospital list and were removed from this analysis.*

- *The data underlying this table is at a different time point compared to the data underlying Figure 14. However, the proportion of hospitals holding second-tier eligibility has remained relatively stable from February 2021 to October 2022.*

Figure 16 shows the proportion of second-tier funded private patient separations by private hospital category, for each financial year. Category G hospitals (day hospitals) account for the majority at around 43% of separations in FY20 (around 28,000 separations). There is a slight increase in the proportion of second-tier funded separations provided in Category B hospitals (rehabilitation hospitals), accounting for approximately 14% of separations in FY20, up from approximately 6% prior to FY19.

Figure 16: Proportion of second-tier funded separations in each private hospital category



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022), Private hospital second-tier category lists*

Interpretation, limits and cautions:

- *The hospitals were categorised using the hospital categories published on the Department of Health and Aged Care website each year from August 2019, as well as the category lists provided by the Department for years prior to 2019. The categories were assumed to refresh each August. However, the lists provided did not include lists for 2018-19 and so, the Declared Hospitals List as at 3 January 2019 was used for separations in the 2018-19 period, with the 2019-20 list used to fill in gaps in the classification of hospital categories. This view uses a different hospital categorisation variable to Figure 13 and Figure 14.*
- *A small number of separations were at hospitals whose provider ID did not match up with a provider ID in the respective hospital category list for the year in which the separation occurred and were removed from this analysis.*
- *Separations in Category E hospitals in FY15 and FY16 were suppressed due to low counts of providers.*

2.3.4.2 Second-tier eligibility requirements

Under Rule 7C of the *Private Health Insurance (Health Insurance Business) Rules* 2018, to be eligible for second-tier default benefits, a hospital must:

- Be a private hospital
- Be accredited against the National Safety and Quality Health Service (NSQHS) by an approved accrediting agency at the time of application

- Not bill patient directly for the minimum benefit payable by the patient's insurer
- Make provision for informed financial consent (IFC)
- Submit HCP data to health insurers electronically with every claim for second-tier default benefits
- Pay an application fee (currently $900 (GST exempt)).

IFC is a requirement of accreditation with the introduction of the NSQHS Standards (second edition) from January 2019.

2.4 Study scope and approach

2.4.1 Study scope

EY was contracted by the Department to conduct an independent study on PHI minimum and second-tier default benefits, including the associated administrative, operational, and regulatory settings. The Department intends to use the findings of this study, in conjunction with the progress of the PL reforms and findings of actuarial studies of LHC and RE, and the Medicare Levy Surcharge (MLS) and PHI Rebate, to identify reform opportunities for the PHI sector regulatory settings for Government consideration.

The objective of this study is to develop a suite of potential reform opportunities to support policy settings aimed at:

- Improving the affordability and value of PHI.
- Improving consumer access to, and participation in PHI.
- Exploring the sustainability of PHI in the context of an integrated private-public health system.

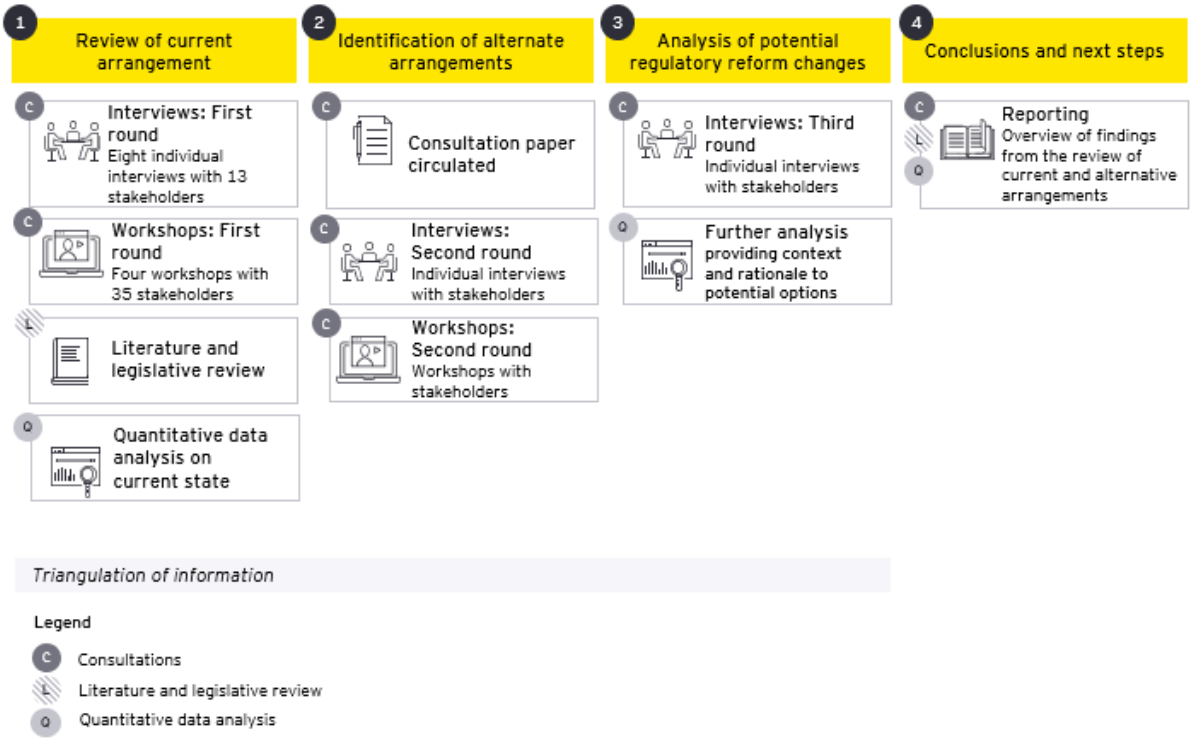
Analysis presented in the report has been limited by time, scope, and data availability. Additional reliance and limitations are included in Appendix A.

2.4.2 Study approach

This study is an independent study into the effectiveness of PHI minimum benefits and second-tier default benefits. The study was carried out in four phases (see Figure 17) and was informed by extensive stakeholder consultation through a variety of forums (including workshops, individual discussions and responses to a publicly released consultation paper[34]), detailed data analysis and literature review/research. More details on the study approach can be found in Appendix C.

[34] Department of Health and Aged Care, 2022. Consultation Paper on Private Health Insurance (PHI) Default Benefit Arrangements. Available at: www.consultations.health.gov.au/medical-benefits-division/consultation-paper-private-health-insurance-defaul/

Figure 17: Study phases



This report presents EY's findings from the study. It is structured in the following way:

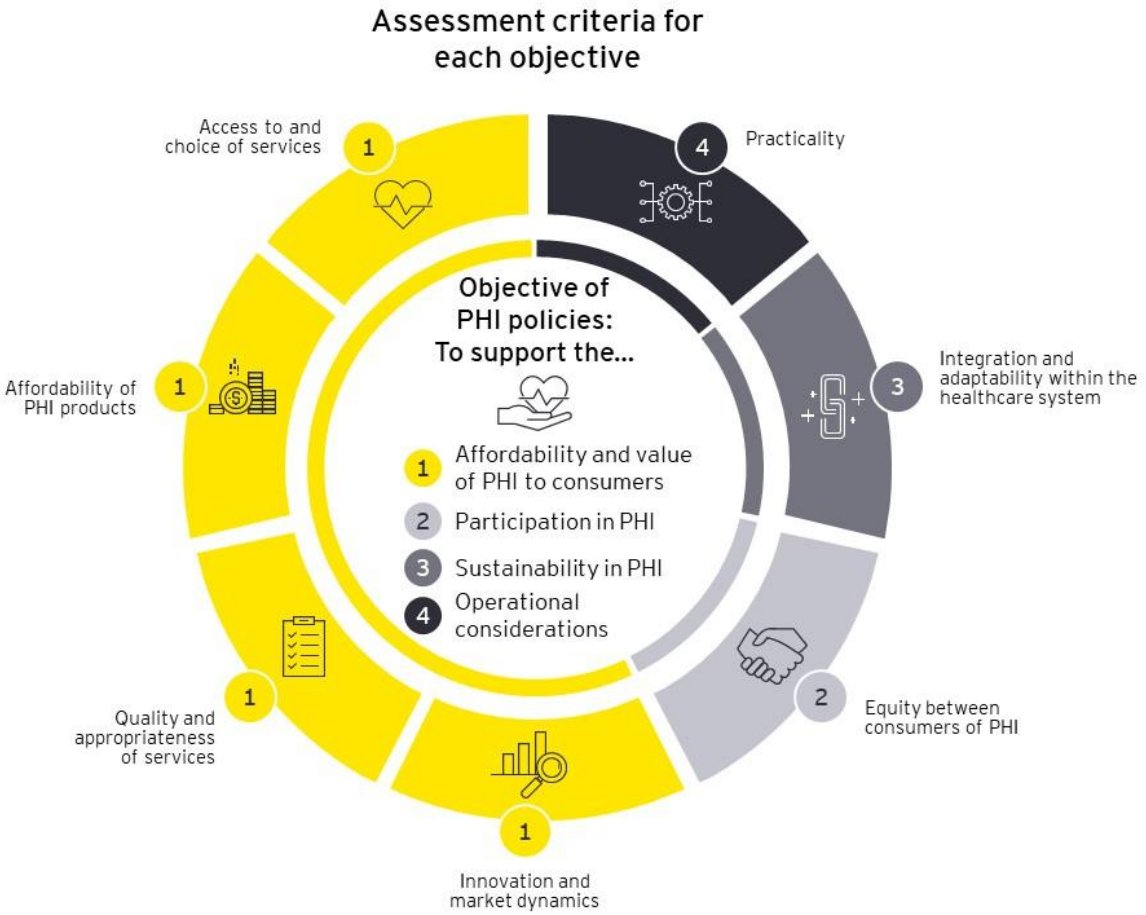
- Section 3 applies the assessment criteria to the current default benefit arrangements. In doing so, we apply a combination of data analysis as well as drawing upon stakeholder feedback (see Appendix C).
- Section 4 introduces opportunities to change default benefits that could address some of the issues identified in Section 3. These opportunities specifically target the different aspects of default benefit arrangements. In each case, we assess how the Opportunity could improve outcomes using the assessment framework and discuss some of the key risks and implementation considerations.
- Section 5 provides two Recommendations for reforming default benefits together with the specifically targeted opportunities from Section 4, whilst also considering underlying process improvements and interactions with broader reforms to PHI.

2.4.3 Assessment criteria

The assessment criteria for this study were designed in consultation with the Department and stakeholders as part of the consultation process (see Appendix C) with the intention that they support the Department's higher-level PHI policy objectives relating to the affordability and value of PHI, participation in PHI and the sustainability of PHI.

The assessment criteria are shown in Figure 18, with a detailed description of each criterion and supporting metrics provided in Table 28 in Appendix C.1.

Figure 18: Assessment criteria



These criteria were selected to ensure coverage of the higher-level objectives for all Government PHI policies, but also to align the purpose of default benefits, as described in Section 2.3.1.

Default benefits interaction with the safety and quality of services

By safeguarding choice, default benefits support consumers in accessing quality and value in healthcare services. A feature of second-tier default benefits is their eligibility requirements, intended to support higher quality/better value healthcare services. The ACSQHC and State and Territory licensing/registration regulators contribute to ensuring minimum safety and quality standards are in place. The ACSQHC supports a nationally consistent assessment framework for all hospitals and day procedure services. Currently, this is the second editions of the NSQHS Standards. National safety and quality accreditation is used as a gauge of compliance with standards and a tool for State and Territory regulators wishing to ensure minimum safety and quality standards are in place. However, adequate hospital funding is required to ensure safety and quality standards can be met. Therefore, there is an interaction between these requirements that needs to be continuously considered.

We consider that safety and quality matters should be considered in the context of the national safety and quality standards and framework, supported with adequate private hospital funding through default benefits and contracting. Issues relating to the safety and quality of default benefit-funded services should not be considered as an indication of the ineffectiveness of default benefits.

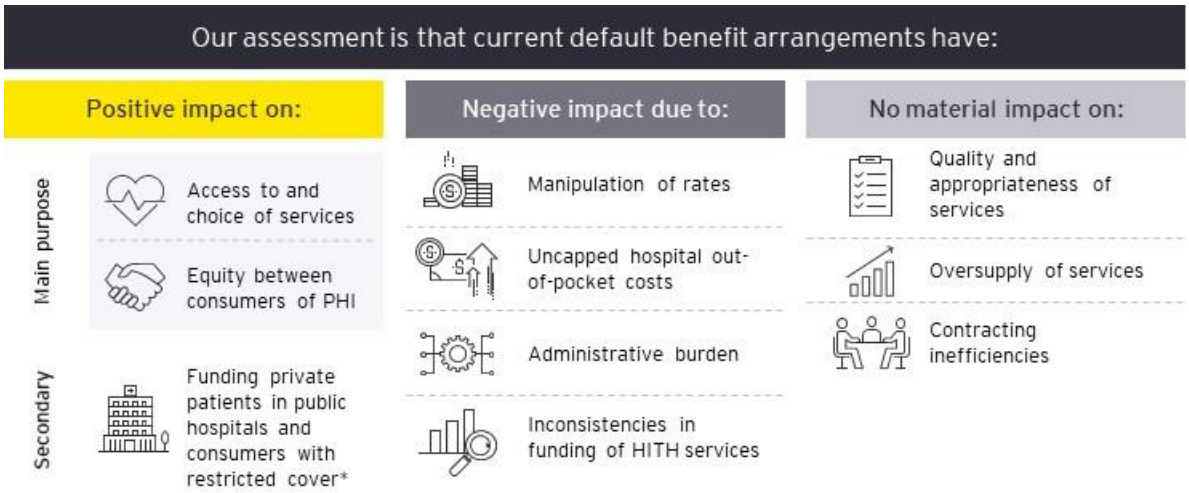
3. Assessment of the current minimum and second-tier default benefit arrangements

This Section provides an assessment of the current state private hospital funding arrangements against the assessment criteria.

Our findings on the assessment of the current state of minimum and second-tier default benefit arrangements are summarised in Figure 19 below, followed by a further description and breakdown of impacts in Table 4.

These findings were informed by applying our assessment criteria (as described in Section 3.1) to the arrangements. Supporting analyses is presented in Sections 3.2 to 3.8. The supporting analysis has been structured by applying the assessment criteria systematically, as described in Section 3.1. The ordering of the findings therefore differs to the summary of findings, which have been structured by positive, negative and neutral impacts.

Figure 19: Summary assessment of current default benefit arrangements



** There are concerns around the benefit of restricted cover for consumers. However, default benefits do support the current policy of restricted benefits.*

Default benefits are an important component of the private healthcare system in safeguarding access and choice and supporting equity. However, there are range of other policy and funding mechanisms that have significant impacts on the supply and demand for private healthcare services, meaning that default benefits cannot be expected to achieve optimal access, choice and equity alone.

In our view, as a mechanism that safeguards consumers to receive insurer funding for private hospital services, default benefits are effective in supporting their main purposes. Other broader changes to environmental settings outside of default benefits would be required to have a direct additional positive impact on access, choice and equity.

However, the effectiveness of default benefit arrangements would be optimised by making changes to the arrangements that reduce or eliminate the negative impacts outlined in Figure 19.

Table 4: Detailed assessment of current default benefit arrangements

Statement in Figure 19	Further description	Reference to analysis in Section 3
Positive impacts		
Access to and choice of services	Our assessment found that default benefits are effective in supporting their key purpose of safeguarding consumer access and choice. In the case that contracts cannot be agreed, default benefits can and do act as a funding safety net and support the continued provision of services for consumers, with insurers paying $150 million[35] in benefits for second-tier funded separations in FY20.	*N/A – See below sections*
	Default benefits provide most support to consumers in accessing services at new hospitals while those hospitals are in the process of negotiating contracts with insurers. Our analysis found that half of new hospitals have contracts with less than 30% of insurers, whereas half of established hospitals have contracts with more than 95% of insurers,[36] pointing to the higher level of support and funding via default benefits in newer hospitals. Through this function, default benefits increase consumer choice by supporting market entry for new hospitals that may also provide innovative and efficient services.	Section 3.2.3
	Although the current utilisation of default benefits has been relatively low, with the value of second-tier default benefits only making up 1%[37] of all insurer benefits paid in FY20, there is a significant possibility that they will be utilised more often as the current inflationary environment leads to more protracted and potentially disputed future contract negotiations. Therefore, default benefits are currently serving an important purpose as a safety net to protect PHI consumers should contracts not be renewed.	Section 3.2.3
	Default benefits currently fund certain service types, such as ophthalmology and rehabilitation, more often than other service types. In the absence of default benefits, consumers may need to seek alternative hospitals for these service types, reducing their access and choice of services.	Section 3.2.1
	There are concerns around the possibility for patients to be charged significant hospital out-of-pocket costs when funded by default benefits as there are no rules limiting the amounts that can be charged to patients.	Section 3.2.2
Equity between consumers of PHI	The safeguarding of consumer access and choice is especially important in regional areas of Australia where there are fewer private hospitals. A halt in services at one hospital could lead to relatively larger adverse effects on the accessibility for consumers in these areas. The safety net function of default benefits supports the equitable access to private hospital services by preventing reduced accessibility for regional consumers in the case that contracts cannot be agreed.	Section 3.5.1

[35] This value was calculated as the sum of hospital benefits and medical benefits (excluding Medicare) for separations that were flagged as being funded by second-tier default benefits. The data source is pre-processed HCP1 data supplied by the Department. For medical benefits, only the benefits paid for separations with a valid medical record were included in the calculation. 68% of second-tier funded separations in FY20 had a valid medical record.

[36] These values were found through analysis of the data.gov.au Agreement Hospitals matrix as at 1 August 2022 and hospital data held by the Department. A hospital was defined as new if its opening date was in 2016 or later. These values are sensitive to this definition and the underlying data.

[37] This value was calculated by dividing the $150 million quoted above by the equivalent calculation for all separations, regardless of the funding arrangement of the separation. Overall, 80% of separations in FY20 had a valid medical record.

Statement in Figure 19	Further description	Reference to analysis in Section 3
Funding private patients in public hospitals and consumers with restricted cover	There were no apparent issues with default benefits fulfilling their other purposes. Although there are no significant issues with the level of minimum benefits for funding private patients in public hospitals, there are opportunities for operational improvements in its calculation and application.	Section 3.6.1
	However, the broader purpose of allowing PHI policies to only offer restricted cover for certain service types and meet product classification criteria should be considered, however is outside the scope of this study. The low level of cover that they offer for these services may lead to significant hospital out-of-pocket costs for consumers.	Section 3.2.2
Negative impacts		
Manipulation of rates	Due to the design of the mechanics that determine the second-tier default benefits, insurers are potentially able to manipulate the rates downwards by including low rates for services in contracts with hospitals that do not provide that service. This may lead to private hospital under-funding and/or consumers paying additional out-of-pocket costs.	Section 3.7.1
Potentially uncapped hospital out-of-pocket costs	There is currently no limit on the level of out-of-pocket costs that can be charged to patients when their separation is funded by default benefits, whereas contracts usually do not allow for any out-of-pocket costs. Although some level of out-of-pocket costs may be required to cover costs under default benefits, the lack of a limit leaves consumers exposed to the risk of significant out-of-pocket costs.	Section 3.2.2
Administrative burden	Aspects of the current arrangements, particularly the wide ranges of second-tier default benefit rates and schedule structures, are inefficient and contribute towards administrative burden for both hospitals and insurers. Ultimately, these costs flow to higher out-of-pocket costs and/or higher PHI premiums for consumers.	Section 3.7.1
Inconsistencies in funding of HITH services	Hospital in the home (HITH) is a model of care that can be more efficient than in-hospital services from a cost perspective and is valued by consumers. However, it cannot be accessed through default benefits. This leads to inconsistencies in the accessibility of HITH services for patients: ► In private hospitals, depending on their choice of insurer and level of cover. ► In public hospitals, depending on whether they are admitted as a public patient (where HITH is funded) or a private patient funded by minimum benefits. These inconsistencies can limit access and be confusing for consumers, as well as hospitals and insurers.	Section 3.4.2
No material impact		
Quality and appropriateness of services	As noted above, we consider that any observed safety and quality issues relating to default benefit-funded services should not be considered as an indication of the ineffectiveness of default benefits. However, adequate funding is required to provide safe and quality services and there are opportunities to reduce the administrative burden of, and improve the consistency between, the various safety and quality standards.	Section 3.3.1
Oversupply of services	Some stakeholders have suggested that default benefits are causing an oversupply of services in metropolitan areas through their support of new hospitals. However, our analysis has not found explicit evidence that oversupply is a material problem and second-tier funded services have been decreasing since FY18 in these areas.	Section 3.4.1

Statement in Figure 19	Further description	Reference to analysis in Section 3
Contracting inefficiencies	Default benefits do not appear to be a significant contributor towards inefficiencies in contracting, given the relatively lower level of second-tier default benefits compared to contracted rates diminishing any "price floor" impact on contracts.	Section 3.4.1

3.1 Application of assessment criteria

The assessment of the current default benefit arrangements has been conducted against the assessment criteria outlined in Figure 18, and our perspectives were informed by information gathered from the stakeholder consultations, including the consultation paper,[38] and data analysis.

We then synthesised our findings based on whether they were positive, negative or neutral into Table 4 above.

As default benefit arrangements by their nature focus on insurer to hospital payments, they have an indirect impact on PHI product affordability (consumer to insurer payments) through any efficiencies/inefficiencies being passed on. For this reason, in this study, the affordability criterion is considered last.

We developed a set of "Statements" which read as aspirational points for default benefit arrangements, with at least one Statement for each assessment criterion. These Statements capture the aspects relevant to default benefits that were identified through our stakeholder consultations. These Statements, and our findings against each Statement, are presented in this Section, noting the following:

- There are aspects of these criteria that overlap/intersect.
- Whilst there may be some overlap between the Statements, we have grouped them so that they introduce different aspects under each assessment criterion.
- The Statements present a comprehensive summary of the issues relating to the current default benefits arrangements that have been identified through this study.

A key limitation of this study is that we do not have data and information on the counterfactual, that is, how the Australian healthcare system would perform and operate without default benefits. This makes it difficult to definitively determine the siloed effect of default benefits on the current state, as well as the potential effect of any changes to default benefit arrangements.

The following sub-sections provide more detail on our analysis to support our findings and assessments. Further, these findings inform the opportunities for change presented in Section 4.

[38] The public consultation paper is available at Consultation Paper on Private Health Insurance (PHI) Default Benefit Arrangements (www.consultations.health.gov.au/medical-benefits-division/consultation-paper-private-health-insurance-defaul/).

3.2 Access to and choice of services

It is important that healthcare is provided when and where needed, and that patients are able to exercise choice. Private health consumers have different requirements regarding their level of insurance cover, healthcare needs, customer service and private hospital services, and insurer differentiation between private hospital services via contracting supports consumer choice. The current default benefit arrangements have been assessed as to whether they support access to appropriate insurer-funded healthcare services including the point at which choice is exercised, without excessive hospital out-of-pocket costs or travel, access to appropriate information and tools to make an informed decision.

Access to and choice of services is assessed under three Statements to explore different aspects of this criterion.

Table 5: Assessment of current arrangements against access to and choice of services

Assessment criteria	Assessment	Our findings
Access to and choice of services	Marginally supported by default benefits	Overall, default benefit arrangements do support consumer access to and choice of services by: ► Providing a safety net in the case that future contracts cannot be agreed, to support the continued provision of services for consumers (see Section 3.2.3) ► Providing a safety net in the current inflationary environment, which may lead to more protracted and potentially disputed future contract negotiations, increasing the utilisation of second-tier default benefits (see Section 3.2.3) ► Providing support for new hospitals until they are able to secure contracts with insurers. There may be some trade-off between reducing barriers to entry and potentially supporting an oversupply of services, which is difficult to decide between at this stage (see Section 3.2.3) ► Providing funding for certain services, such as ophthalmology and rehabilitation, which are funded more often by second-tier default benefits (see Section 3.2.1) However, default benefits do not seem to currently play a large role in this criterion as: ► Default benefits are currently supporting a relatively small volume of services (see Section 3.2.1) ► Default benefits do not have a material effect on the geographical accessibility of services (see Section 3.2.1) Although the quantitative analysis around hospital out-of-pocket costs was inconclusive due to data limitations, there were concerns around significant hospital out-of-pocket costs being charged to a relatively small number of patients in the absence of a contract with the patient's insurer. This is due to the lack of a limit on the level of hospital out-of-pocket costs that can be charged to patients funded by default benefits. Further, in the case that the patient only holds restricted cover for the required service, the patient could face significant out-of-pocket costs (see Section 3.2.2).

3.2.1 Statement 1: The current arrangements support the funding of a range of services that are convenient to the patient

This Statement is explored in two parts:

► Funding of a range of health services.

► Funding of services that are convenient to the patient.

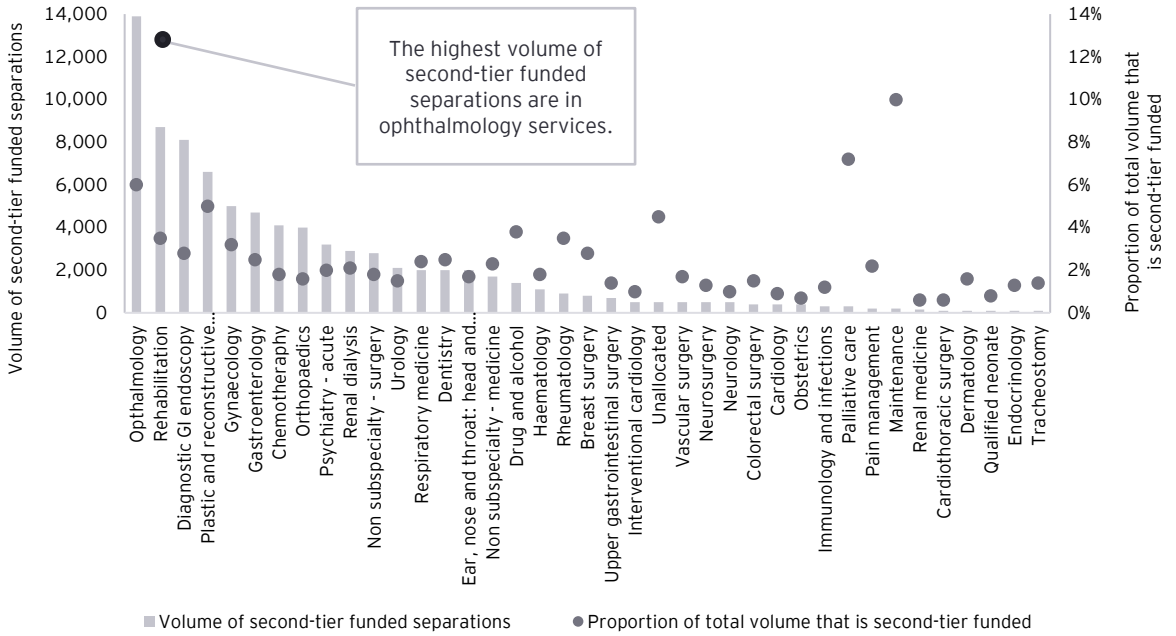
Range of health services

The extent to which current funding arrangements support the provision of a range of services for consumers was assessed by exploring historic usage of second-tier default benefits by service type, as identified by service-related groups (SRGs). The types of services with higher historic usage of second-tier default benefits provide an indication of which services appear more supported under current arrangements. It should be noted that:

- The mix of services that meet consumers' health needs may be different to the mix of services that are supplied.
- Even though the overall usage of default benefits is relatively low, the historic utilisation of default benefits do not necessarily inform future utilisation in the case that contracts fall through. This aspect is further explored in Section 3.2.3.
- As mentioned in Section 3, there is no counterfactual to compare the current state to a system without default benefits, making it difficult to definitely determine the siloed effect of default benefits on the range of services supported.

Although overall volumes of second-tier funded separations have been relatively low, ophthalmology services, in particular, as well as rehabilitation, diagnostic GI endoscopy and plastic and reconstructive surgery services have had higher volumes of separations funded by second-tier default benefits compared to other SRGs (Figure 20). This suggests that hospitals providing these services, particularly those that specialise in these services, have a lower rate of contracting and are currently more supported by the default benefits.

Figure 20: Average annual volume of second-tier funded separations and its proportion of total volume, from FY15 to FY20, by SRG (ordered by average annual volume of second-tier funded separations)



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *Represents the average annual volume of second-tier funded private hospital separations nationally, and its proportion of the total average annual volume from FY15 to FY20, by SRG.*
- *The SRG classification categorises admitted patient episodes into groups representing clinical divisions of hospital activity, based on aggregations of AR-DRGs. The unallocated SRG refers to separations that weren't able to be allocated to an existing SRG based on how the classifications are defined.*
- *The transplantation, extensive burns, perinatology and psychogeriatric care SRGs have been removed due to low provider and/or separation counts or lack of data.*

There were differing views amongst stakeholders as to the importance of the role played by default benefits arrangements in supporting consumer access:

- Private hospitals consider that default benefits promote access to services in an environment where the large size and bargaining power of some insurers allows them to selectively contract.

- On the other hand, insurers consider that default benefits are unnecessary and that contracting already provides sufficient access for consumers. From a supply perspective, it is suggested that default benefits contribute towards an oversupply/supply-induced demand of services in metropolitan areas and/or support lower value services. These insurer perspectives are explored in Section 3.2.3 and Section 3.3.1, respectively.

Findings

Default benefits are used across different services. However, there are some services, such as ophthalmology, rehabilitation, endoscopy and plastic and reconstructive surgery, that have higher volumes of separations funded by second-tier default benefits.

Whilst this may suggest that default benefits currently support patient access and choice to these services, the lack of a counterfactual limits the ability to assess the impact of default benefits on consumer access and choice. In the absence of default benefits, this may lead to increased contracting and/or reduced patient access and choice.

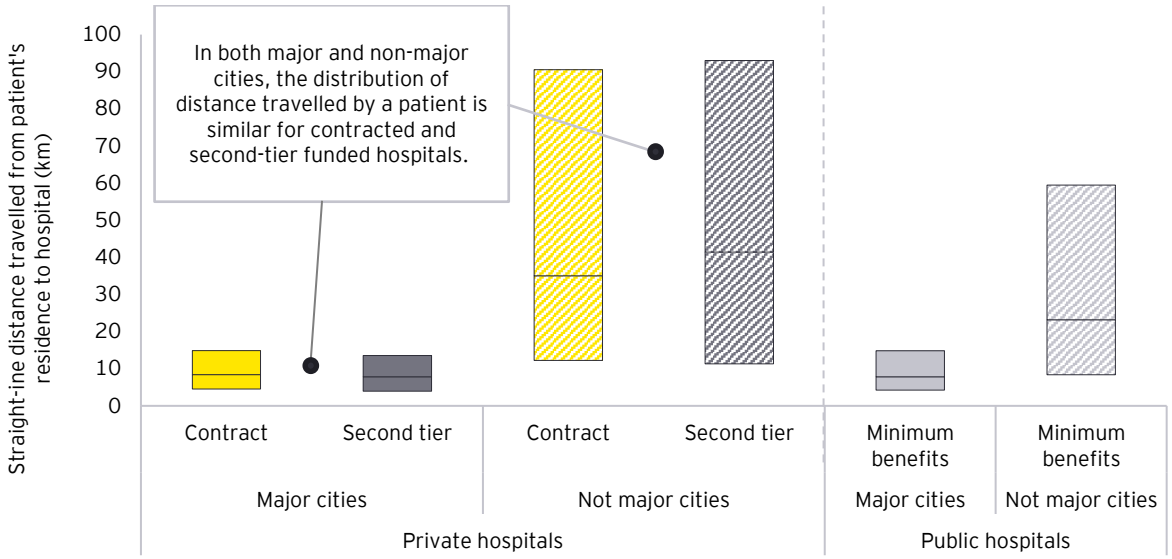
Convenience of services

The convenience of services supported by current arrangements was assessed by analysing the proxy of distance between a patient's residence and the hospital at which they were treated. The analysis showed that distance travelled by patients does not materially differ between contracted and second-tier funded hospitals (Figure 21). However, it is important to note that the private facility that a patient attends for treatment is likely more driven by a GP's referral or specialist of choice, rather than the contract status of a hospital.

Non-metropolitan areas exhibit lower relative utilisation of default benefits (Figure 13, page 23), suggesting the higher prevalence of contracting in these hospitals. However, consumers in these areas have a lower PHI participation rate (Figure 22). The possibility remains that, if default benefits were more effective in non-metropolitan areas, they could incentivise more non-metropolitan consumers to take up PHI by providing improved access. That said, other factors, such as the socioeconomic profile of consumers in these areas and the lower accessibility of private hospitals in non-metropolitan areas compared to metropolitan (Figure 21) are more likely to be driving the lower value proposition of PHI products for these consumers than issues related to the availability of insurer funding.

As the distance travelled to second-tier funded hospital services and contracted hospital services in non-metropolitan areas is relatively similar, it does not appear that the lower accessibility of private hospitals would be significantly improved by changes to the default benefit arrangements themselves.

Figure 21: Distribution of straight-line distance from patient's residence to hospital in FY20, by contract status and patient location

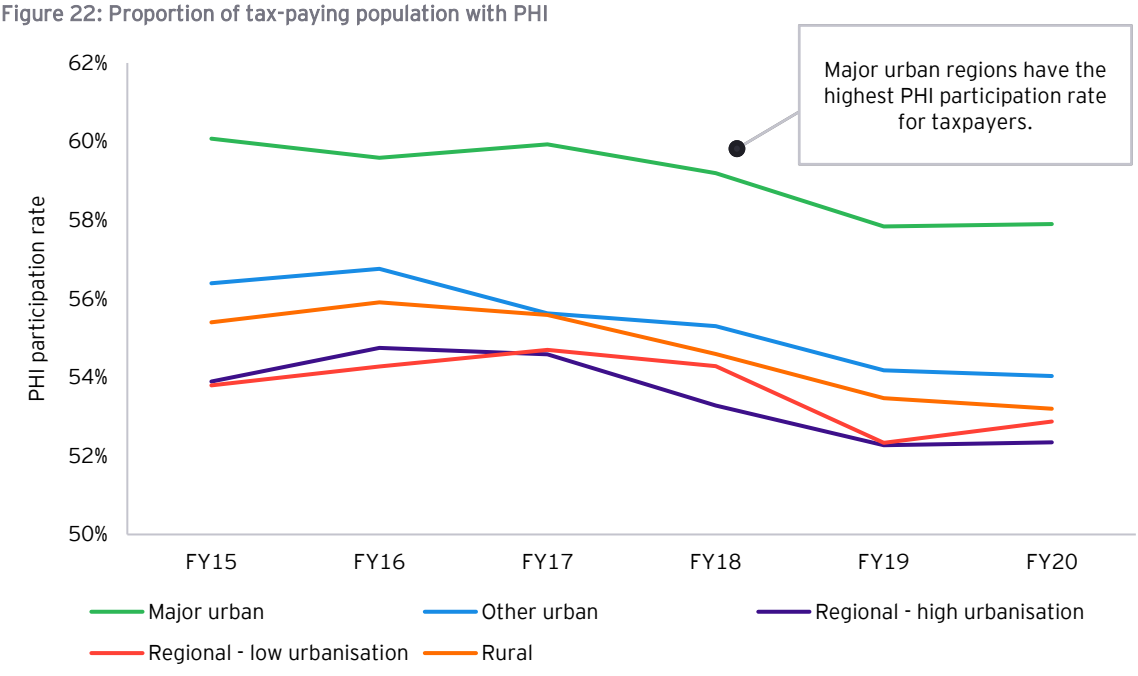


Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022) and hospital data held by the Department*

Interpretation, limits and cautions:

- *The figure is a box-and-whisker plot without the whiskers and shows the Q1, median and Q3 of the distribution.*
- *The patient location categories were derived using the patient postcode reported in HCP1 and the Modified Monash Model (MMM) Suburb and Locality Classification available on the Department's website.*
- *The travel distance between the hospital and patient's residence was calculated as a straight line distance from the hospital to the centroid of the patient's postcode. The latitude and longitude of the hospital was provided by the Department and the latitude and longitude of the patient's postcode was estimated using a database of postcodes available at Australian Post Codes - Matthew Proctor. As the latitudes and longitudes were available for each locality within each postcode, the average was calculated and mapped to each patient postcode.*
- *This analysis excludes hospitals that share a provider ID as the data does not identify which hospital under the provider ID the patient was admitted.*

Figure 22: Proportion of tax-paying population with PHI



Data source: *Australian Taxation Office individual sample files (2% sample)*

Interpretation, limits and cautions:

- *Represents the proportion of taxpayers in Australia with PHI in each financial year, by region.*

- *Region is based on the geographic regions used by the ATO.*
- *Note that the range of the vertical axis varies from 50% to 62%.*
- *This analysis was performed on a 2% sample of records provided by the ATO. Thus, the analysis assumes that the 2% sample provided is representative of the total population for each financial year.*
- *The regions provided by the ATO are categorised for each state but were grouped in the analysis for interpretability of the graph.*

Findings

The convenience of private hospital services does not materially differ between contracted services or services funded by default benefits. However, the private facility that a patient attends for treatment is likely primarily driven by a GP's referral or specialist of choice and the patient's pathway through the healthcare system, while the contract status of a hospital with the patient's insurer has a more indirect effect. A change to current default benefit arrangements is unlikely to materially affect the patient's choice of hospital.

The accessibility of private hospital services is lower in non-metropolitan areas, possibly contributing to the lower PHI participation rate in these areas. Although this issue cannot be completely addressed through default benefits, it is important to continue to support these areas through default benefits due to the downside risk of contracts falling through exacerbating the lower accessibility for consumers. Stakeholder perspectives saw the most alignment on current arrangements having value to regional consumers and providers.

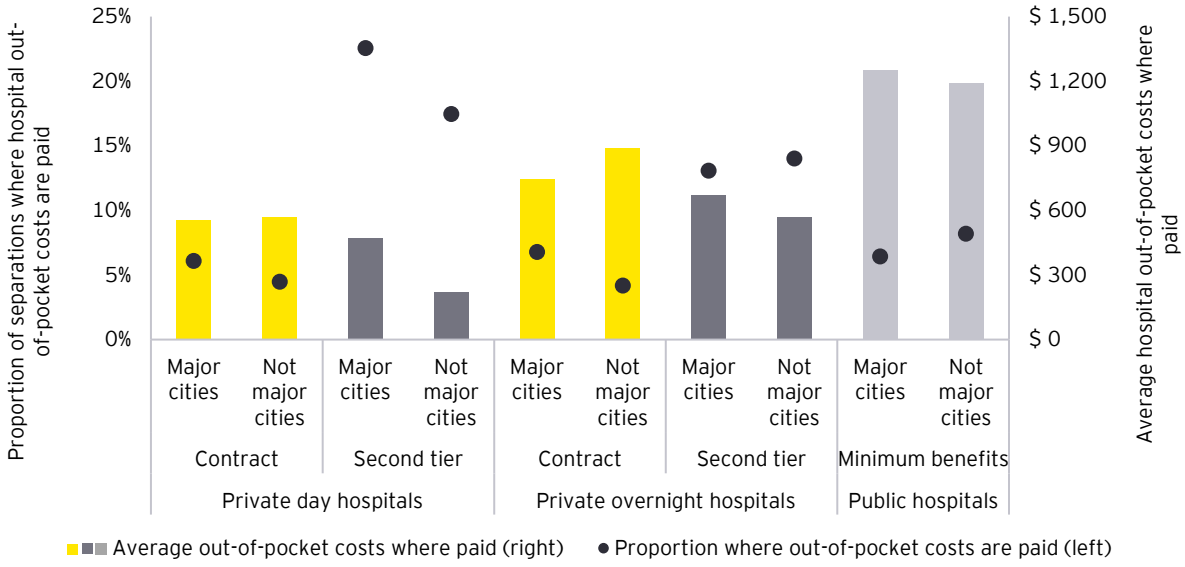
3.2.2 Statement 2: The current arrangements limit hospital out-of-pocket costs

This Statement was assessed by exploring the average hospital out-of-pocket costs paid by patients by hospital type, location and SRG. This Section focuses on the hospital (and not medical) out-of-pocket costs paid by patients on top of any front-end deductibles (policy excesses and/or co-payments). The front-end deductible was removed from the hospital out-of-pocket costs as this amount is largely driven by the PHI policy purchased by a consumer and is not expected to be significantly impacted by contracting or lack thereof between hospitals and insurers.

Our analysis (Figure 23) shows that a higher proportion of second-tier funded separations compared to contracted separations include hospital out-of-pocket costs on top of the front-end deductible. However, where hospital out-of-pocket costs are paid, the average hospital out-of-pocket costs are higher for contracted separations.

However, this trend may be affected by the data limitations outlined in Section 2.3.2, where "contracted" separations with hospital out-of-pocket costs payments may actually refer to separations that were funded by second-tier default benefits. Therefore, it is recommended that further assessment of out-of-pocket costs is conducted following the data improvements outlined in Section 5.2.1, in particular, improvements to capturing the funding arrangement of a specific separation.

Figure 23: Proportion of separations where hospital out-of-pocket costs is paid on top of the front-end deductible and the average out-of-pocket costs for these separations, by hospital type, contract status and hospital location



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Limits and cautions in interpretation:

- *The hospital location categories were derived from the Modified Monash Model (MMM) categories, where a MM 1 category is major city and MM 2 to 7 were grouped to represent not major cities.*
- *The identification of hospital type is based on the "Declared information management system hospital type" flag within the HCP1 data. Private overnight hospitals refer to those with a hospital type of "private other".*
- *The out-of-pocket costs in this analysis is represented as the total hospital charge minus the total hospital benefit minus the front-end deductible for a separation.*
- *This analysis is based on the hospital out-of-pocket costs paid for separations from FY15 to FY20 (inclusive), indexed to 2022-23 using the inflation rates from IHACPA's NEP Determination reports. An out-of-pocket cost is considered to be paid if it is greater than $1 pre-indexation.*
- *A non-material number of separations where the out-of-pocket costs was less than -$1 was excluded from this analysis.*
- *There has been data cleansing performed on the underlying HCP1 dataset by the Department of Health and Aged Care, which include exclusion of separations where the rounded benefit exceeds the rounded charge by more than $1, and the exclusion of separations where the derived total hospital charge or benefit exceeds $500,000. For detailed exclusions applied, please refer to the explanatory notes within the HCP Annual Report[39].*

Further analysis on hospital out-of-pocket costs paid in public hospitals by state, average medical out-of-pocket costs paid and average hospital and medical out-of-pocket costs by SRG are available in Appendix F.1.

Although stakeholders held opposing opinions on this Statement, there was no direct disagreement, with the following key points made:

- Hospitals expressed their preference to not charge out-of-pocket costs but viewed them as an important mechanism to support the viability of their business when funded by default benefits or restricted benefits, as well as being a point of differentiation to incentivise contracting.
- Insurers have stated concerns around the absence of a price ceiling on the level of out-of-pockets that can be charged to patients.

[39] Department of Health and Aged Care. 2021. Hospital Casemix Annual Reports. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

Findings

Patients seem to pay hospital out-of-pocket costs more often when their separation is funded by second-tier default benefits than contracted rates. Stakeholders agreed on their preference to not charge hospital out-of-pocket costs as these costs undermine the value proposition of a PHI product for consumers.

However, some level of out-of-pocket costs may be necessary in the absence of a contract to meet the short-term cashflow needs of the private hospital, while acting as a mechanism to promote reaching a contractual agreement between a hospital and insurer. Nevertheless, there have been concerns of high out-of-pocket costs being charged to some patients.

There is an opportunity to legislate a cap on out-of-pocket costs to balance accessibility for consumers and hospital viability. This is explored in Section 4.2.1.

Restricted cover

Some PHI products offer restricted cover for some service types, where the insurer only pays the minimum benefit even if there is a contract between that insurer and the patient's private hospital. There are no apparent issues with minimum benefits in fulfilling this other purpose. However, in the case that a patient is treated at a private hospital for a service with restricted cover, this can leave the patient with significant out-of-pocket costs. This raises questions around the broader purpose of allowing PHI policies to only offer restricted cover for certain service types.

Findings

Although there are no apparent issues with the current default benefits in fulfilling its other purpose of providing funding for service types with restricted cover, the broader purpose of allowing PHI policies to only offer restricted cover for certain service types should be considered, however is outside the scope of this study.

3.2.3 Statement 3: The current arrangements provide a safety net in cases where contracts cannot be agreed

This Statement was assessed by exploring to what extent the rate of contracting varies between different hospital characteristics. Lower rates of contracting generally indicate cases where contracts cannot be agreed and thus, where default benefits are used to determine insurer benefit amounts.

The key questions here are around what level of intervention should be made by the Government to ensure consumers' needs are met while allowing market forces to function, and the extent that default benefits should act as a safety net should contracts not be agreed.

A number of factors were analysed to investigate the drivers of lower contracting rates. From this analysis, how recently the hospital opened or whether the hospital was part of a larger group were characteristics that had lower rates of contracting. As such, this Section focuses on these hospitals. Analysis on other hospital characteristics and their rate of contracting is shown in Appendix F.2.

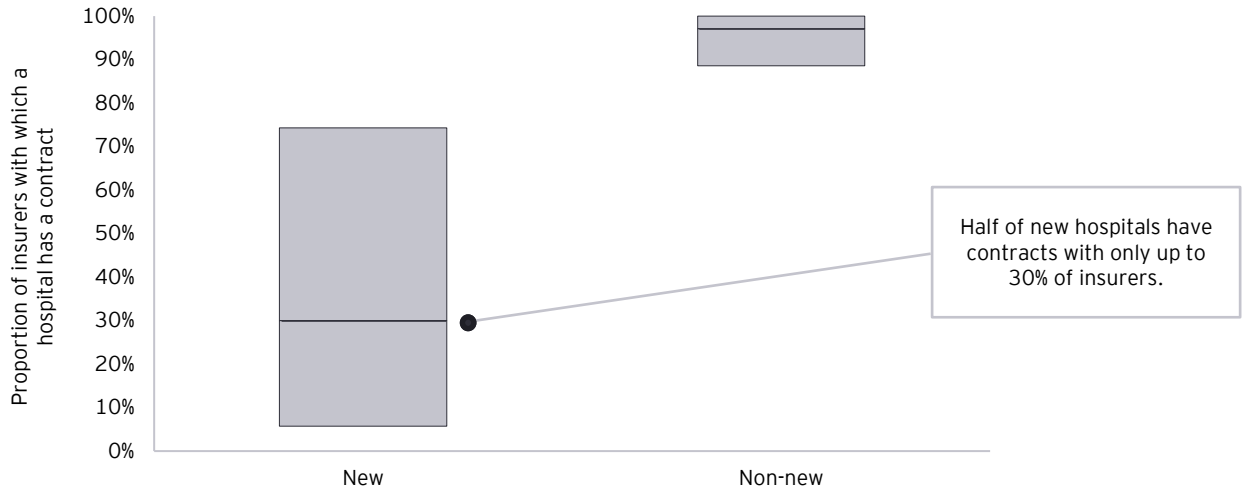
New private hospitals

New private hospitals have a markedly lower rate of contracting than established private hospitals. There are differing interpretations of the impact of this:

- Hospitals have expressed that default benefits provide an avenue for new providers to enter the market and receive funding while they prove their viability to insurers before contracting. This is seen to be particularly important for innovative and highly specialised service providers that may provide more efficient and appropriate care depending on the patient's needs.

- Insurers have argued that this has led to the oversupply of services and/or dilution of existing services in certain areas, particularly metropolitan areas of major cities, detracting from the investment in areas where consumers have a lower accessibility to, and therefore, higher need for services.

Figure 24: Proportion of insurers with which a hospital has a contract, by hospital opening date



Data source: *Data.gov.au Agreement Hospitals matrix 1 August 2022, Hospital data held by the Department*

Interpretation, limits and cautions:

- *The boxplot presents the distribution of the proportion of insurers that a hospital is contracted with as at 1 August 2022 for different hospital characteristics. For a given hospital, this is calculated by the following:*

$$Proportion\ of\ insurers\ that\ a\ hospital\ is\ contracted\ with = \frac{Number\ of\ insurers\ indicated\ as\ having\ a\ contract}{Total\ number\ of\ insurers\ in\ Agreement\ Hospitals\ matrix}$$

- *The box represents the range between the 1st quartile and 3rd quartile of percentages, i.e., 50% of hospitals lie in this box.*
- *A hospital is defined as "new" if its opening date is in 2016 or later. Outputs are sensitive to this definition and the underlying data.*
- *Hospitals that were missing opening date data were excluded from the analysis Data quality issues with this variable may impact the distributions shown.*
- *A smaller number of hospitals may result in a seemingly larger range between the 1st and 3rd quartile, purely due to the smaller number of observations with a large range. However, a large range in values may be an indication of the need of a safety net.*

Findings

Default benefits are often used to support new private hospitals in the first few years of opening. It is likely that there are cases where this is contributing to oversupply, supply-induced demand and/or dilution of existing services, although this is difficult to establish given the range of other factors that influence demand for services and determining where the supply is inefficient. However, supporting competition between private hospitals and reducing barriers to entry for innovative and efficient service providers is important for the Australian healthcare system. The downside risk of oversupply needs to be balanced against providing a smooth pathway for high value innovative providers to establish themselves in the market.

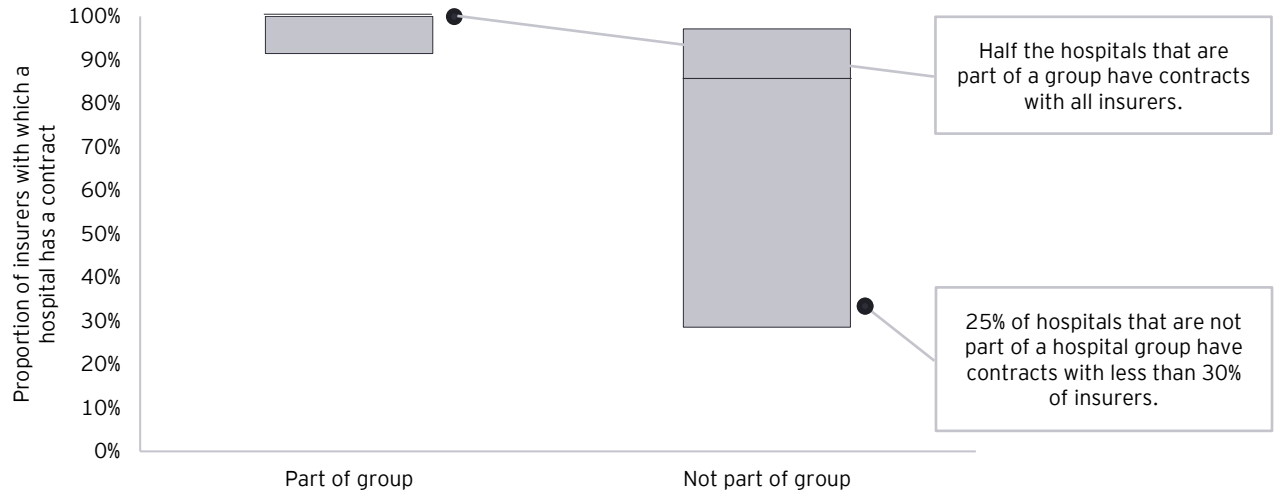
The question of oversupply and a potential opportunity for reform is further discussed in Section 3.4.1 and Section 4.3.1, respectively.

Independent private hospitals

Independent private hospitals also have a lower rate of contracting than private hospitals that are part of a group. These private hospitals tend to be small, specialised hospitals. Hospital stakeholders have expressed that there is not enough market incentive for insurers to negotiate contracts with these independent, smaller, more specialised providers, which aligns with the trends shown in the data. On the other hand, insurers have argued that competition between insurers drives contracting in all areas of the market.

Independent private hospitals would not experience the economies of scale that large private hospital groups do through their availability of resources to negotiate contracts with insurers for multiple hospitals at once. Independent private hospitals tend to provide highly specialised services for consumers, which some may argue are more efficient. Again, there needs to be a balance between supporting these types of services for consumers and the level of market intervention by the Government.

Figure 25: Proportion of insurers with which a hospital has a contract, by owner group



Data source: *Data.gov.au Agreement Hospitals matrix 1 August 2022, Hospital data held by the Department, Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The boxplot presents the distribution of the proportion of insurers that a hospital is contracted with as at 1 August 2022 for different hospital characteristics. For a given hospital, this is calculated by the following:*

$$Proportion\ of\ insurers\ that\ a\ hospital\ is\ contracted\ with = \frac{Number\ of\ insurers\ indicated\ as\ having\ a\ contract}{Total\ number\ of\ insurers\ in\ Agreement\ Hospitals\ matrix}$$

- *The box represents the range between the 1st quartile and 3rd quartile of percentages, i.e., 50% of hospitals lie in this box.*
- *A hospital is defined as "part of group" if its owner owns 2 or more hospitals. Outputs are sensitive to this definition and the underlying data.*
- *Hospitals that were missing the owner data were excluded from the analysis. Data quality issues with this variable may impact the distributions shown.*

Findings

Independent private hospitals are supported by default benefits with market dynamics favouring large private hospital groups. The highly specialised services provided by these independent private hospitals are important for consumers and the Australian healthcare system. The risk on consumers and the broader system of taking away this support is not yet fully understood and requires further consideration.

Inability to reach agreements between hospitals and insurers

The other key situation where default benefits act as a safety net is in the case that future contracts cannot be agreed upon. As contract negotiations across the private healthcare sector are ongoing, default benefits are currently serving an important purpose as a safety net to protect PHI consumers should contracts not be renewed. There have been examples of high-profile cases between large insurers and private hospitals where this has been close to occurring.

Such a situation could result in large adverse effects in the accessibility of services for patients, especially in non-metropolitan areas, with already lower accessibility to private hospitals. In the current climate of increasing health inflation, the contracting environment is likely to be more fraught and it is reasonable to expect there may be more disputes. This may lead to higher usage of default benefits in the future than there have been in the recent past.

Findings

Default benefits act as a safety net in case future contracts cannot be agreed upon, protecting the accessibility of services for consumers. However, due to the lack of historic cases where default benefits have been used as a safety net for private hospitals, the importance of this function of default benefits is unclear. In addition, even when default benefits do replace contracting for a specific insurer/hospital combination, consumer choice and access would remain supported by other providers or other pathways in the health system.

However, it could be risky to consumers to test the importance of this safety net and it is reasonably likely that default benefits will serve the purpose of a safety net in the near future for a large number of consumers. This function of default benefits should be heavily considered when exploring reform that reduces the accessibility of default benefits for some or all hospitals.

3.3 Quality and appropriateness of services

It is important that any healthcare provided to patients is of a high standard of quality as well as appropriate to the health needs of the patient. Consumers should have confidence in the quality of services they will receive, in relation to outcomes, standards and processes.

A feature of second-tier default benefits is their eligibility requirements, intended to support high quality/better value healthcare services. The ACSQHC and State and Territory licensing/registration regulators contribute to ensuring minimum safety and quality standards are in place. The ACSQHC supports a nationally consistent assessment framework for all hospitals and day procedure services. Currently, this is the second editions of the NSQHS Standards. National safety and quality accreditation is used as a gauge of compliance with standards and a tool for State and Territory regulators wishing to ensure minimum safety and quality standards are in place. However adequate hospital funding is required to ensure safety and quality standards can be met. Therefore, there is an interaction between these requirements that needs to be continuously considered.

We consider that safety and quality matters should be considered in the context of the national safety and quality standards and framework, supported with adequate private hospital funding through default benefits and contracting. Issues relating to the quality and safety of default benefit-funded services should not be considered as an indication of the ineffectiveness of default benefits.

Quality and appropriateness of services is assessed under one Statement.

Table 6: Assessment of current arrangements against quality and appropriateness of services

Assessment criteria	Assessment	Our findings
Quality and appropriateness of services	Neutral	Overall, default benefits do not appear to directly affect the quality and appropriateness of services provided. Although there is some insurer lack of confidence in the quality of some private hospitals service operations with higher utilisation of second-tier default benefits, this does not appear to be caused by default benefit arrangements. However, there are opportunities for improvements in the current mechanisms supporting reporting relating to safety and quality, to reduce administrative burden and to contribute to a sector with consistently high-quality services for patients.

3.3.1 Statement 4: The current arrangements support appropriate high-quality services

This Statement explores:

- Indicators of quality and appropriateness of care, including if and how they differ between contracted and private hospitals with high utilisation of second-tier default benefits
- Mechanisms ensuring the safety and quality of care in the current private healthcare sector

Indicators of quality and appropriateness of care

Quality and appropriateness of services was assessed by exploring the rate of unplanned readmissions and the rate of four procedures (tonsillectomy, myringotomy, gastroscopy and lumbar spinal fusion) identified in ACSQHC's Atlas of Variation[40,41]. These procedures are identified by the ACSQHC Atlas of Variation as having potentially unwarranted variation, suggesting potential sub-optimal healthcare delivery. Note that the ACSQHC has also developed a list of avoidable hospital readmissions[42] to inform safety and quality reforms in Australia, as well as maintaining specific unplanned readmission indicators. We observed that:

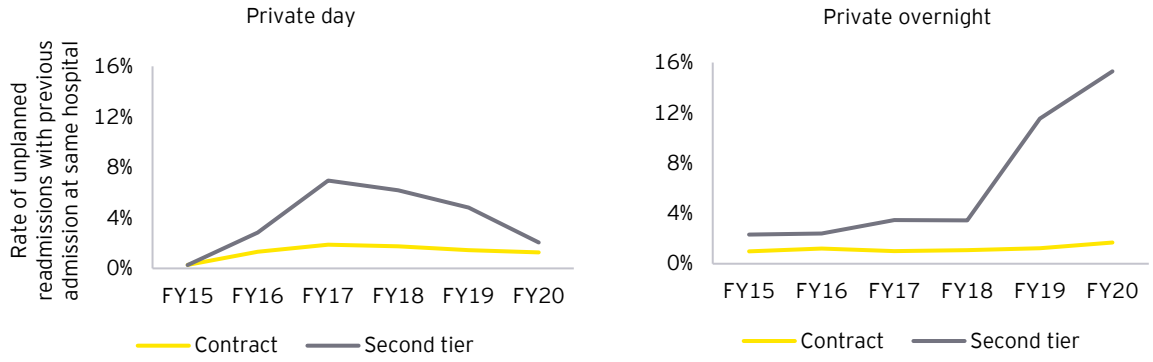
- The rate of unplanned readmissions to the same hospital was marginally higher for second-tier funded separations compared to contracted separations (Figure 26), with the biggest difference seen in private overnight hospitals as opposed to private day hospitals from FY18 onwards. The reason for the sharp rise in readmissions among the second-tier group is unclear. It is recommended that this trend be further investigated.
- There was a higher rate of procedures with potentially unwarranted variation (such as tonsillectomy, see Figure 27) in contracted separations. Similar findings can be seen across other procedures with potentially unwarranted variation, such as myringotomy, gastroscopy and lumbar spinal fusion, the analysis for which can be found in Appendix F.3. This supports the notion that contracts may not support the provision of higher quality treatments for patients. However, it should be noted that the procedure performed is often determined by the decisions of clinicians rather than the hospital and thus the contract status of a hospital may have more of an indirect role in facilitating potentially sub-optimal services.

[40] Australian Commission on Safety and Quality in Health Care. 2021. The Fourth Australian Atlas of Healthcare Variation. Available at: www.safetyandquality.gov.au/sites/default/files/2021-04/The%20Fourth%20Australian%20Atlas%20of%20Healthcare%20Variation%202021_Full%20publication.pdf

[41] The definitions of the four procedures of interest were based on the ACSQHC Atlas of Healthcare Variation.

[42] The list of avoidable hospital readmissions is available at Avoidable hospital readmissions (www.safetyandquality.gov.au/our-work/indicators/avoidable-hospital-readmissions).

Figure 26: Proportion of total separations where the separation was an unplanned readmission and the patient was previously treated at the same hospital, for each contract status and private hospital type

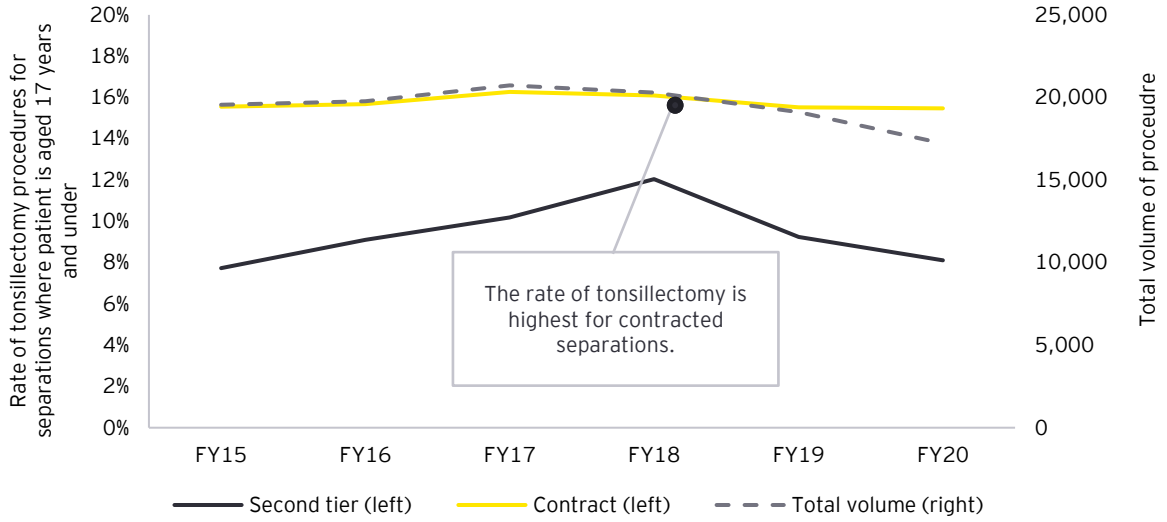


***Data source**: Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The identification of unplanned readmissions is based on the "Re-admission within 28 days" variable in the HCP1 data, where the value of this variable is "unplanned re-admission and patient previously treated in this hospital".*
- *The identification of hospital type is based on the "Declared information management system hospital type" flag within the HCP1 data. Private overnight hospitals refer to those with a hospital type of "Private other".*
- *The hospital contract status that the data is attributed to is based on the status for the readmission. The hospital contract status of the initial admission may differ from that of the readmission.*

Figure 27: Rate and volume of tonsillectomy hospitalisations in private hospitals for patients 17 years and under



***Data source**: Pre-processed HCP1 data and accompanying procedure data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *Tonsillectomy is a procedure that was identified by the ACSQHC as having potentially unwarranted variation and suggests sub-optimal healthcare delivery in the Atlas of Variation. A tonsillectomy hospitalisation was identified in the data using AIHW data specifications and the procedure data accompanying HCP1. Only separations where the accompanying procedure data is available were included in this analysis.*
- *This chart only includes private hospitals separations due to the lower quality of procedure data for public hospital separations.*
- *The rate of tonsillectomy procedures is calculated as, where the patient is 17 years and under, the number of separations with a tonsillectomy procedure divided by the total number of separations.*

Findings

We found no consistent link between the contract status of a hospital and the quality and appropriateness of care provided to its patients. However, there are potential areas of concern that should be monitored, such as the specific private overnight hospitals contributing to the increasing rate of readmissions. Although there is a difference in the rates of potentially sub-optimal services (as identified and described in ACSQHC's Atlas of Variation) between second-tier funded and contracted separations, the provision of these services is primarily driven by the clinician's decisions rather than the contract status of the private hospitals. **Thus, the arrangements themselves do not obviously improve or diminish the care provided at a sector level.**

Mechanisms ensuring safety and quality

Stakeholder opinions on the mechanism to best promote quality and appropriateness varied by stakeholder group. Insurers identified non-price conditions in contracts as an effective mechanism to support quality services, while hospital stakeholders stated the underlying accreditation with NSQHS Standards should be the mechanism to support quality and that this is not the role of insurers.

As mentioned above, the ACSQHC and State and Territory licensing/registration regulators contribute to ensuring minimum safety and quality standards are in place. Any concerns regarding providers would be more appropriately addressed by these bodies, than through reform to default benefit arrangements.

There is a view that monitoring and meeting all the different quality conditions in contracts, as well as adhering to the NSQHS Standards, adds to the hospitals' administrative burden and costs and detracts their focus from the provision of healthcare for their patients. Table 7 outlines three different areas of safety and quality requirements currently imposed on private hospitals by different stakeholders, and the potential issues with each area.

Table 7: Areas of safety and quality requirements on private hospitals

Area of requirements	Description	Potential issues
Accreditation/licensing/ registration	► Accreditation against NSQHS Standards is available for licensed hospitals who are assessed by the ACSQHC and when successful are awarded accreditation for 3 years[43]. ► Interim accreditation is awarded to new hospitals, with a 12-month provision for full accreditation. ► The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme provides for the national coordination of the accreditation process. Under the AHSSQA Scheme, ACSQHC approves accrediting agencies to assess health service organisations to determine compliance with the NSQHS Standards. ► Licensing/registration of hospitals is assessed by States and Territories, with each jurisdiction having their own legislated requirements.	► We have seen potentially concerning rates of readmission (see Figure 26), particularly for second-tier funded separations. ► This provision may lead to variations in safety and quality during this time, potentially increasing the risk of harm to consumers. ► There have been suggestions of varying licensing/registration requirements across the different jurisdictions.

[43] From 1 July 2023 short notice accreditation assessments to the NSQHS Standards will be in place. More info at: ACSQHC Short Notice Accreditation Assessment (www.safetyandquality.gov.au/publications-and-resources/resource-library/fact-sheet-17-short-notice-accreditation-assessment).

Area of requirements	Description	Potential issues
Second-tier eligibility	► There are no additional safety and quality requirements in second-tier eligibility as the NSQHS accreditation requirement is part of declaration process. ► This area is assessed by the Department.	► Benefit amounts are linked to contracts, but without associated terms and conditions, diminishing effectiveness of contracting and potential performance risk. ► The timeliness of accreditation processes affects when hospitals can apply for second-tier eligibility.
Contract terms and conditions	► Contracts currently include safety and quality KPIs and requirements. ► This area is assessed by individual insurers.	► There is contention as to the appropriateness of insurers including safety and quality terms and conditions, given there is already a national accreditation process conducted by the ACSQHC. ► There are administrative inefficiencies associated with differences in requirements in contracts and there have been suggestions for an agreed set of indicators of quality. ► However, it is important to retain some level of contracting differentials to support a competitive market, especially in relation to standards of patient care.

Findings

There is significant contention around the sufficiency and application of NSQHS standards that all declared hospitals are required to meet. Concerns around the safety and quality standards of hospitals would be more appropriately addressed through refinement of these standards and its application than through default benefit arrangements.

There are still potential opportunities for minimising the administration of various safety and quality standards and improving consistency across the sector. This should be balanced with allowing contracts to retain differentials to accommodate for competitive market dynamics. This is further explored in Section 4.2.3.

3.4 Innovation and market dynamics

It is important that the delivery of services in the healthcare system continues to evolve through innovation to optimise patient outcomes, as well as improve efficiency and productivity. Market dynamics are especially important in the private healthcare system to support the consumer's choice of services and the affordability of private health services and PHI products.

Innovation and market dynamics is assessed under two Statements to explore different aspects of this criterion.

Table 8: Assessment of current arrangements against innovation and market dynamics

Assessment criteria	Assessment	Our findings
Innovation and market dynamics	Marginally not supported by default benefits	The current arrangements do not appear to have a significant impact on the dynamics of the competitive market (see Section 3.4.1), as: ► The extent to which second-tier default benefits influences contracting by setting a "price floor" is difficult to estimate, but is expected to have a small impact on contracted rates and premium levels. ► The extent to which default benefits supports an oversupply of services in metropolitan areas is also difficult to conclude, but initial analysis suggests oversupply is not a growing problem.

Assessment criteria	Assessment	Our findings
		► There are opportunities to improve the efficiency of contract negotiations, such as refinements of the National Procedure Banding Committee's (NPBC) processes and recommendations. Current arrangements do not support innovative services, such as HITH services, as these services are not within the scope of default benefits, which only funds in-hospital services (see Section 3.4.2). This is causing inconsistencies in the availability of these services and can be confusing for consumers, hospitals and insurers. However, there are currently many different providers of HITH and there are some examples of collaborations between hospitals and insurers to fund and provide these innovative services for consumers under contract arrangements.

3.4.1 Statement 5: The current arrangements support a competitive free market for private hospitals and private health insurers

This Statement is explored in three parts:

- Impact of the current arrangements on contract negotiations.
- Effectiveness of the National Procedure Banding Committee (NPBC) in supporting contract negotiations.
- Impact of the current arrangements on supply of hospital services.

Contract negotiations

Contracting between hospitals and insurers is generally seen by most stakeholders as being the preferred method for ensuring consumers have access to efficiently priced services in a private healthcare sector.

A concern from the private health insurer sector is that second-tier default benefits disincentivise contracting and set a "price floor" on contract rates that unduly influence contract negotiations, even when a contract is agreed, and comes with an efficiency cost to the system. The hospital sector disputes this, pointing to factors such as the relative concentration and bargaining power of insurers in negotiations, and that the default rates are too low to represent a viable alternative to a contract being agreed.

Findings

Whilst the assertion that default benefits influence contracting is logical, it is difficult to confirm and estimate its impact. However, given that the level of second-tier default benefits appears to be often substantially lower than contracted rates[44], and second-tier default benefits are rarely used in practice[45], the "price floor" effect is expected to be diminished and have a relatively minor impact on contracted rates. Further, as PHI premium levels are determined based on a number of different factors, including other claims costs (such as prostheses and medical), insurer expenses and insurer business decisions, the impact of a "price floor", if any, on premiums would be small.

[44] Refer to Figure 31 and Figure 32, page 59, and corresponding discussion in Section 3.7.1

[45] Refer to Figure 10, page 21

The National Procedure Banding Committee (NPBC)

The NPBC[46] is a steering committee comprising of private hospital and health fund nominees that oversees the management, maintenance and update of procedure bands. The Committee acts in an advisory capacity and is not a regulatory body.

Currently, the NPBC assigns new MBS items to one of fifteen procedure bands, with each band representing a cost range required to provide that service. The bands are intended to simplify contract negotiations between hospitals and insurers by providing recommendations on the prices for 15 bands rather than each of the 5,000 procedures listed in the MBS, based on costs. However, many issues have been identified in the current function and processes of the NPBC:

- With only an advisory function, and without legislative powers, insurers and private hospitals are not required to consider the NPBC recommendations when forming contracts.
- The current number of procedure bands is not adequate for more complex surgeries, such as coronary stents, which are often more costly to perform.
- As MBS items are banded when they are introduced, the banding committee's recommendations have been reported as ineffective in adapting to changes in procedure technology or processes that may impact the costs of supplying a service.
- Due to the equal representation from private hospitals and private health insurers, the NPBC can reach a stalemate in decision making, causing a delay in recommendations for new items.

The procedure bands defined by the NPBC may be used as a patient classification system/payment structure within the calculation of the second-tier default benefits. As such, any issues and limitations in the procedure bands may have flow-on effects to the second-tier default benefit rates. However, there is no clear link between the effectiveness of the procedure bands defined by the NPBC and default benefits.

Findings

The effectiveness of the NPBC's recommendations in supporting contract negotiations is unclear. There is potential for the NPBC's recommendations to provide a base for contract negotiations, with a focus on costs to provide a service. However, there are several inefficiencies and limitations, as noted above, that will need to be addressed to support a more widespread usage of the banding recommendations in contract negotiations. There is no clear link between the effectiveness of the procedure bands defined by the NPBC and default benefits.

Supply of services

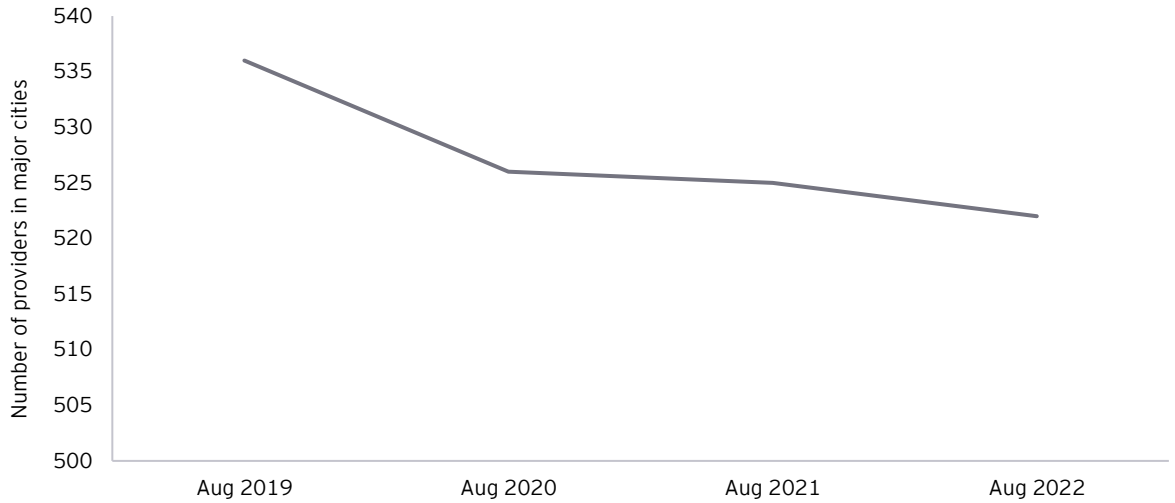
There have been suggestions that default benefits ease the entry of new hospitals by guaranteeing funding, especially in urban areas where consumer access to services is not an issue. This has the potential implications on system efficiency by creating an oversupply of services and diluting high quality services. The quality of services has been discussed in Section 3.3.

Although it is true that default benefits have higher utilisation in metropolitan areas (Figure 13) and for services provided in recently opened hospitals (Figure 24), our analysis suggests that an oversupply of services is difficult to prove and to separate from genuine consumer needs being met, especially with an ageing population and increasing health expectations of a developed society. More specific and targeted analysis, coupled with clinical input, would be required to further investigate and confirm or deny that there is an oversupply of services.

[46] The Terms of Reference for the NPBC are available at NPBC ToR (www.dayhospitalsaustralia.net.au/wp-content/uploads/2016/08/Hunt-MP-The-Hon-Greg-DHA-Briefing-paper-on-NPBC-TofR-Attach-21.9.17.pdf).

The number of private hospitals in metropolitan areas has been declining since 2019 (Figure 28). This suggests that, although there are new hospitals opening in metropolitan areas during this period, more hospitals are closing. However, this could be causing a change in the distribution of the location of hospitals within major cities.

Figure 28: Number of private hospitals in major cities over time



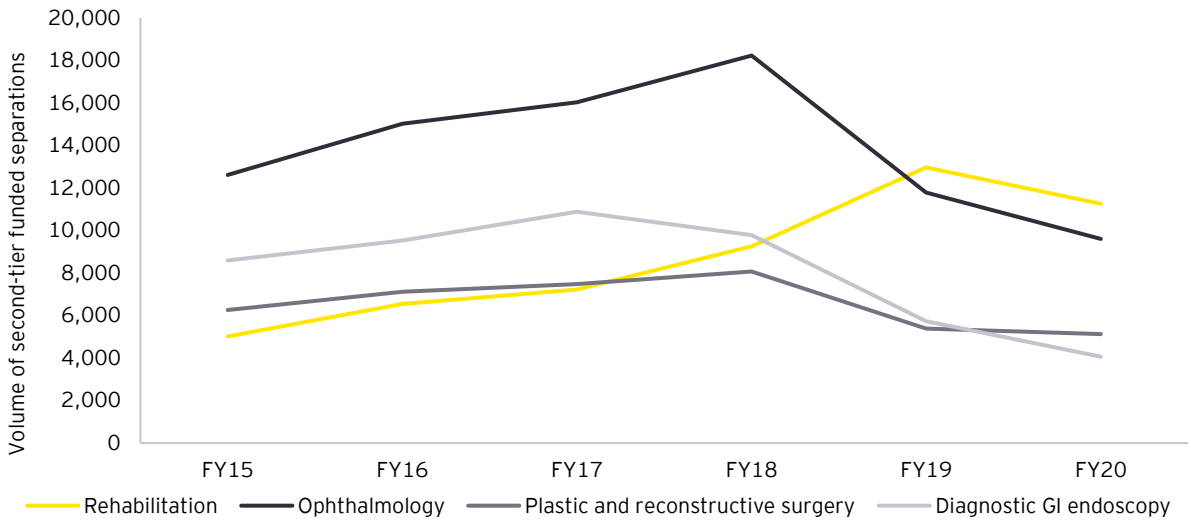
***Data source**: Second-tier category lists, hospital data held by the Department, MMM to postcode mapping published by the Department*

Interpretation, limits and cautions:

- *Hospitals in major cities were identified where the hospital's MMM classification is 1.*
- *Where the hospital data held by the Department did not have a corresponding MMM classification, the MMM to postcode mapping was used to manually classify the hospital.*
- *Note that the range of the vertical axis is from 500 to 540.*
- *Second-tier categorisation was only performed by the Department and published since August 2019. HCP1 data was not used for this analysis due to the data quality of provider IDs.*

Out of the SRGs identified in Section 3.2.1 with a high volume of second-tier separations, ophthalmology, diagnostic GI endoscopy and plastic and reconstructive surgery all exhibited increasing volume of second-tier separations from FY15 but have dropped off from FY18 (Figure 29). Rehabilitation services have shown a steady increase in volume to FY19. Again, it is difficult to separate these services from meeting genuine consumer needs but, if there is any existing oversupply, the data does not indicate that the trend is persisting in recent years.

Figure 29: Volume of second-tier funded separations for top 4 SRGs by second-tier volume from FY15 to FY20



Data source: Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)

Interpretation, limits and cautions:

- *This chart presents the volume of second-tier funded separations over time for the SRGs with the top 4 highest average annual volume of second-tier funded separations, as identified in Figure 20.*

Findings

Although default benefits support the entry of new hospitals, stakeholder perspectives that funding through default benefits is leading to an oversupply of services in certain areas are difficult to definitively prove or deny with an ageing population and increasing health expectations providing a basis for increases in the volume, and changes to the nature, of services. Our initial analysis suggests that oversupply in metropolitan areas is not a growing problem, but this issue should be monitored.

3.4.2 Statement 6: The current arrangements support patients to receive innovative health services

This Statement was assessed by exploring the prevalence of HITH services in privately insured separations as an indicator of innovative health services. HITH services are seen as being more efficient from a cost perspective as well as being an option that is valued by consumers.

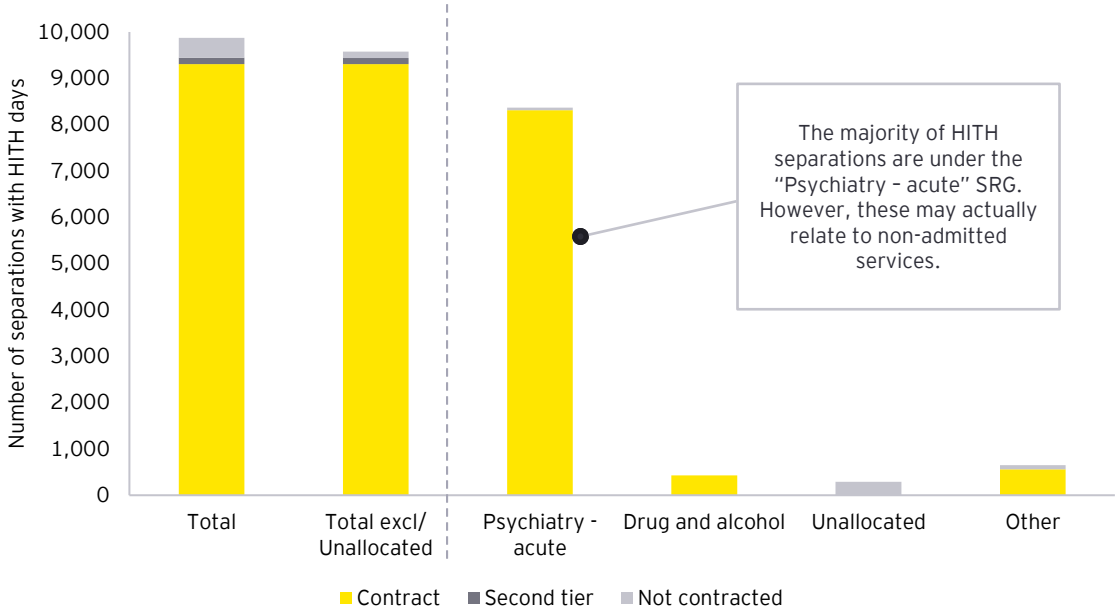
The overall volume of separations with a HITH component is low at less than 10,000 separations in FY20 (Figure 30), compared to a total volume of privately insured separations of around 4 million. The majority of these separations with HITH component are funded through contracts. It should be noted that these separations are only those that are reported under HCP1, and there may be other HITH services in a patient's pathway that are not captured in this data.

When split by SRG, a majority of separations with HITH days fall under the Psychiatry – acute SRG. However, in the release of the 2020-21 HCP and PHDB Annual Reports[47], the Department noted that there is an issue with the data involving the supply of non-admitted service data. An Australian Refined Diagnosis Related Group (AR-DRG) that particularly relates to this issue is U60Z (Mental health treatment W/O ECT, same day), which makes up all HITH separations under the Psychiatry – acute SRG.

This suggests that the actual prevalence of HITH services within hospital separations is likely lower than what is reported in HCP1. Thus, neither the current contracting arrangements and default benefit arrangements encourage or support the provision of HITH care according to this data.

[47] Department of Health and Aged Care. PHI 25/22 Release of 2020-21 HCP and PHDB annual reports. Available at: www.health.gov.au/news/phi-circulars/phi-2522-release-of-2020-21-hcp-and-phdb-annual-reports

Figure 30: Number of separations with HITH days in FY20, by SRG and contract status



***Data source**: Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The identification of HITH care was based on a "number of days of hospital in the home care" value of greater than 0.*
- *The volume of second-tier separations has been suppressed in the last 4 columns due to low separations and/or provider counts. The volume of not contracted" separations has also been suppressed for "Drug and alcohol".*
- *The "other" column refers to separations with HITH days under all other SRGs.*

There are concerns that HITH is currently not eligible for default benefits as this disincentivises HITH services being offered by second-tier funded hospitals, especially in cases where HITH may lead to a better outcome for the patient. Hospital stakeholders have highlighted the large up-front investment required to establish HITH services to demonstrate their success to health insurers until they are able to negotiate contracts with each fund to pay for the innovative service.

This issue can also create a difference in care pathways available to:

- Patients in public hospitals, where public patients are funded for HITH services (HITH services are funded if delivered in line with each state's guidelines) while private patients in public hospitals cannot access HITH services through minimum benefits.
- Patients in private hospitals, depending on the relationship between the patient's chosen insurer and private hospital.

However, we have heard of and seen several examples of contracting and collaboration in the private healthcare sector that supply and fund HITH services for patients, including:

- My Home Hospital – a joint service run by Medibank and Calvary in South Australia.
- Ramsay Connect – a national provider of home and community-based healthcare and support, with arrangements with a vast majority of insurers.
- Bupa and Cabrini Health partnership providing homecare without additional out-of-pocket hospital costs.

Findings

The current arrangements are contributing to inconsistencies in the accessibility of HITH services for patients, depending on whether they elect to be treated as a private patient in a public hospital and their insurer of choice when treated in private hospital. This can be confusing for consumers, as well as hospitals and insurers.

However, in the current system there are many different providers of HITH with examples of contracting and collaboration between hospitals and insurers to supply and fund HITH services. There are broader opportunities to support these services by improving the contracting environment and the availability of funding for HITH services.

3.5 Equity between consumers

It is important that all aspects of healthcare services offered are equitable for all PHI consumers, regardless of their location or required service.

Equity between consumers is assessed under one Statement.

Table 9: Assessment of current arrangements against equity between consumers

Assessment criteria	Assessment	Our findings
Equity between consumers	Marginally supported by default benefits	Default benefits contribute to the equitable access of services for all consumers, by ensuring some level of private health insurer funding regardless of the consumer's choice of hospital or insurer. Although there appears to be some disparity in the geographical convenience of services, default benefits do not appear to be a cause of, nor the appropriate solution to, this issue.

3.5.1 Statement 7: The current arrangements support access to health services for all consumers, regardless of location, and private health insurer

A key element of the policy objective of default benefits is equitable access to privately insured healthcare services for all consumers, regardless of their choice of insurer and location. Access to privately insured services was assessed in Section 3.2 and found that consumers in regional and rural Australia experience lower accessibility to private hospitals (Figure 21). However, as discussed in that Section, default benefit arrangements do not seem to be contributing to this issue.

Hospitals with certain characteristics, such as new or independent hospitals, are more often supported by default benefits (as seen in Section 3.2.3). The consumers of these hospitals are supported through insurer funding which might not be there in the absence of default benefits. However, there is not an obvious consumer cohort with a clear equity need that is met by hospitals with these characteristics.

Findings

Default benefit arrangements are intended to support privately insured patients in accessing a service, regardless of the presence of contracts and without having to pay significant hospital out-of-pocket costs. The number of patients who benefit from this is relatively small, with only around 2% of private hospital separations being funded by second-tier default benefits each year. It is difficult to conclude that default benefits to date have had a strong impact at directly supporting equity of access.

However, removing default benefits could significantly impact on the equitable access to care in some areas where there is limited choice if future contracts are unable to be agreed upon. See Section 3.2.3 for further discussion of the importance of default benefits as a safety net for consumers.

3.6 Integration and adaptability within the healthcare system

A wide range of services are insurer funded and integrate with the public and primary health system to provide continuity of care for patients. The availability, accessibility and nature of services should be able to adapt to changing demand and expectations of the public, as well as shocks to the healthcare system such as the recent pandemic.

Integration and adaptability within the healthcare system is assessed under one Statement relating to impacts on the public system.

A separate aspect of integration and adaptability within the healthcare system is the private patient pathway from initial GP visit through to private hospital treatment, and including any other appointments prior to treatment, as well as prehabilitation and rehabilitation. A Statement considering this has not been included given the relatively minor scope of default benefits, limiting its ability to influence many aspects of that pathway, which is primarily driven by decisions and advice provided by the GP and medical specialists (as discussed in Section 3.2.1).

Table 10: Assessment of current arrangements against integration and adaptability within the healthcare system

Assessment criteria	Assessment	Our findings
Integration and adaptability within the healthcare system	Supported by default benefits	Minimum benefits play a major role in providing the funding mechanism for private patients in public hospitals. There are no apparent issues with the level of minimum benefits, but opportunities for improvements in their calculation and application. However, second-tier default benefits currently play only a small role in supporting consumer access to private hospital services to reduce the burden on the public healthcare system.

3.6.1 Statement 8: The current arrangements support the public healthcare system

This Statement is explored in two parts:

- Reducing the burden on the public healthcare system.
- Supporting private patients in public hospitals.

Reducing the burden on the public healthcare system

The private healthcare system in Australia plays an important role in reducing the number of patients and burden on the public healthcare system. This assists in ensuring that public patients, especially emergency patients, can be cared for in a timely and appropriate manner. As mentioned in Section 2.1, a significant volume of separations are provided in private hospitals each year.

From Section 3.2, default benefit arrangements currently play a small role in supporting consumer access to private hospital services. However, it can be expected that these arrangements will play a larger role if future contracts cannot be agreed. This would enable private hospitals to continue to reduce burden on the public system.

Findings

Default benefit arrangements currently have a minor role in supporting consumer access to private hospitals to reduce the burden on the public healthcare system. It can be expected that this role will increase in the future with the current inflationary climate leading to disputes in contract negotiations.

Supporting private patients in public hospitals

Minimum benefits are primarily used to fund private patients in public hospitals, contributing more than $1 billion in funding to public hospitals each year, with 12-14% of public hospital separations where the patient elects to be treated as a private patient from FY15 to FY20 (Table 11). The policy intent and effectiveness of private patients in public hospitals is a separate area outside the focus of this study. It is difficult to separate the intent and effectiveness of the policy from its funding mechanism through minimum benefits. However, it should be noted that some consumers benefit from the opportunity to elect as a private patient as they are given the opportunity to gain value from their PHI product, especially in areas with lower accessibility to private hospitals. This is evident as, on average, around 31%[48] of privately insured separations in regional and rural areas occurred in public hospitals in each year from FY15 to FY20, compared to only 15%[49] in metropolitan areas.

There are no apparent issues with legislated levels of minimum benefits as a funding mechanism for private patients in public hospitals. They set a level of private funding (currently around $400[50] for overnight shared ward accommodation) that appears to be significant enough to warrant a deliberate policy focussed on the funding of private patients in public hospitals, nor too large that they dominate public funding for these treatments and overly impact PHI claims costs.

Further, the benefits are tied to accommodation benefits only, aligning with the differential consumer benefit of a private room offered to private patients. The public hospital receives the rest of its funding through activity-based funding under the National Health Reform Agreement (NHRA), which applies private patient service and accommodation adjustments to the funding under the NEP model, prostheses funding through the PL, Medicare funding, and hospital out-of-pocket costs (if any). Stakeholders did not express concerns about the level of funding through minimum benefits.

Table 11: Volume and benefits paid for privately insured separations in public hospitals

	FY15	FY16	FY17	FY18	FY19	FY20
Privately insured separations in public hospitals (A)	814,702	871,902	911,707	905,599	881,544	808,853
Total hospital benefits ($bn)	$ 1.047	$ 1.090	$ 1.158	$ 1.173	$ 1.201	$ 1.104
Public hospital separations (B)	5,980,338	6,272,481	6,508,696	6,647,615	6,845,296	6,730,042
Proportion of public hospital separations electing to be private (=A/B)	13.6%	13.9%	14.0%	13.6%	12.9%	12.0%
Privately insured separations (C)	4,270,878	4,473,878	4,542,778	4,667,047	4,714,063	4,431,057

[48] This value is calculated as the number of privately insured separations in public hospitals with an MM category of 2-7 divided by the number of separations in all hospitals with an MM category of 2-7. The data source for this value is Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022).

[49] This value is calculated as the number of privately insured separations in public hospitals with an MM category of 1 divided by the number of separations in all hospitals with an MM category of 1. The data source for this value is Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022).

[50] The minimum benefits are set by the Government as outlined in the *Private Health Insurance (Benefit Requirements) Rules 2011*.

	FY15	FY16	FY17	FY18	FY19	FY20
Proportion of privately insured separations occurring in public hospitals (=A/C)	19.1%	19.5%	20.1%	19.4%	18.7%	18.3%

***Data source**: AIHW Admitted patient care data 2017-18 and 2020-21, pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The volumes are sourced from AIHW data. It should be noted that the volumes of privately insured separations in public hospitals in HCP1 make up around 85% of the AIHW volumes in each financial year.*
- *The total hospital benefits are from HCP1. Due to the ongoing incompleteness of HCP1 compared to AIHW, the actual total hospital benefits paid by insurers for privately insured public hospital separations is likely to be higher than that shown.*

However, there are some issues relating to the calculation and application of minimum benefits, including:

- Currently, the minimum benefit rates are legislated in the *Private Health Insurance (Benefit Requirements) Rules 2011* with little transparency in how these rates are calculated or indexed.
- Public health sector stakeholders have commented on the administrative resourcing and effort required for billing to the private sector as too high and burdensome.
- There is some evidence that hospital out-of-pocket costs on top of front-end deductibles for private patients in public hospitals can be high (Figure 23). This goes against the stated intention of public hospitals and consumer access, especially as there is the no gap alternative of being treated as a public patient. However, there have been comments that public hospitals will absorb the difference between the hospital charge and benefit, and not charge the patient hospital out-of-pocket costs. This requires further investigation and indicates a possible data improvement opportunity to better identify the costs that are actually paid by the patients (see Section 5.2.1).
- Further to the above, there have been suggestions that public hospitals do not pass on excesses or front-end deductibles to consumers. Whether PHI policies should be able to have excess amounts for private patients in public hospitals is a separate question and is not explored in this study.

Findings

There are no significant issues with the level of minimum benefits currently funding private patients in public hospitals. However, there are opportunities for refinement and further clarity in the calculation and application of minimum benefits in public hospitals. Opportunities for reform around minimum benefits are discussed further in Section 4.1.3.

3.7 Practicality

It is important that the operational requirements of the healthcare system are sufficient to support a functional system, while not being too excessive to detract focus from the provision of quality services for all consumers.

Practicality is assessed under one Statement.

Table 12: Assessment of current arrangements against operational considerations

Assessment criteria	Assessment	Our findings
Operational considerations	Not supported by default benefits	There are several aspects in the current default benefit arrangements that are creating an administrative burden and cost on industry stakeholders. These are contributing towards hospital out-of-pocket costs and/or higher PHI premiums for consumers.

3.7.1 Statement 9: Operationalisation of the current legislative arrangements is efficient in practice

This Statement is explored in four parts:

- Implementation of rates.
- Transparency and efficiency of rates.
- Medical contracting undermining the intent of default benefits.
- Timeliness of accreditation and licensing/registration.

Implementation of rates

There are a broad range of rates and structures in contracts between hospitals and insurers and this flows through to the range of second-tier default benefits calculated for each insurer each year. Detail about the second-tier calculation methodology is noted in Section 2.3.4.1.
From a review of the 2021 schedules provided for this study by the Department[51], we observed that the structures, in terms of the inclusion, groupings and descriptions for services with corresponding rates, of these second-tier default benefit schedules differ widely. The complexities in these schedules arise from factors such as:

- **Patient classification system** – Benefits vary from case payments by MBS to funding by diagnosis related groups (DRGs), which is a casemix classification used for admitted patient services, and include combinations of the two.
- **Costs included within benefits** – Benefits may include costs such as theatre, drugs, dressing, disposables, consumables, allied health and/or pharmaceuticals, however not all schedules specify the scope of costs.
- **Accommodation** – the schedules generally differentiate the accommodation benefits by service and care type, such as advanced surgical, surgical, obstetric, medical, rehabilitation, psychiatric care, day surgery and/or palliative care. Not all service and care types are included within all schedules. Rates generally differ by length of stay bands and consist of a step-down structure, however the schedules differ in their treatment of private rooms, with some schedules assigning a different rate for private rooms, and others where there is an additional add-on rate for private rooms.
- **Theatre** – the schedules assigned rates by theatre band, with some using the multi-procedure rule for primary, secondary and tertiary procedures.
- **Hospital category** – most schedules differentiated between the hospital categories, with generally different rate structures between hospital categories.

[51] There were five representative contract schedules sampled alongside audit certificates for three other insurers. Consistent with the advice of private hospitals and health insurers, there are different levels of detail and variations contained within these schedules, with some containing general notes around when the benefits can be paid, while others refer to accompanying business rules in a separate document.

► **State** – most schedules provided different second-tier default benefit rates for each state.

This range of structures and rates has been said to cause significant administrative burden for both insurers and hospitals, in the preparation, checking and billing of second-tier default benefits each year.

Further, the current calculation method can lead to different rates being paid for a similar service, depending on the patient's insurer, jurisdiction in which the hospital is located and category of the hospital at which the service was provided. This is illustrated in Figure 31 and Figure 32, which show how hospital benefits (excluding prostheses) vary for the top AR-DRGs, for both same-day and overnight separations. Although the range in benefits for overnight procedures can be partially attributed to varying length of stay, the ranges seen across all these high-volume procedures are suggestive of possible inefficiencies in administration and pricing.

Figure 31: Distribution of hospital benefits (excluding prostheses benefits) paid for the top 5 AR-DRGs in same-day separations

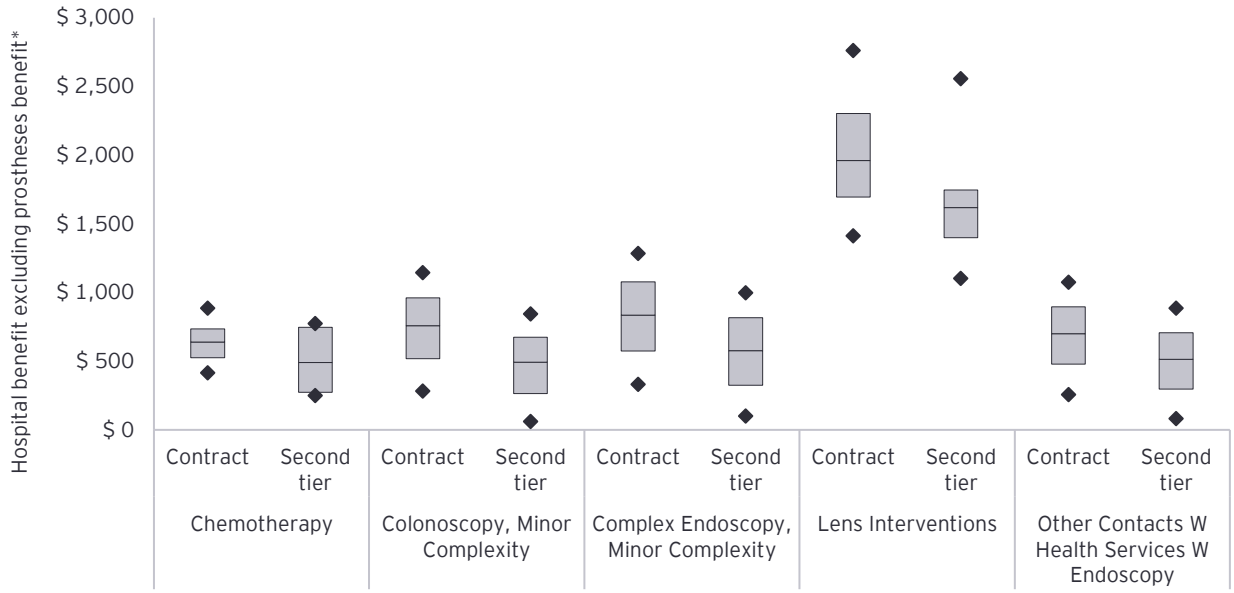
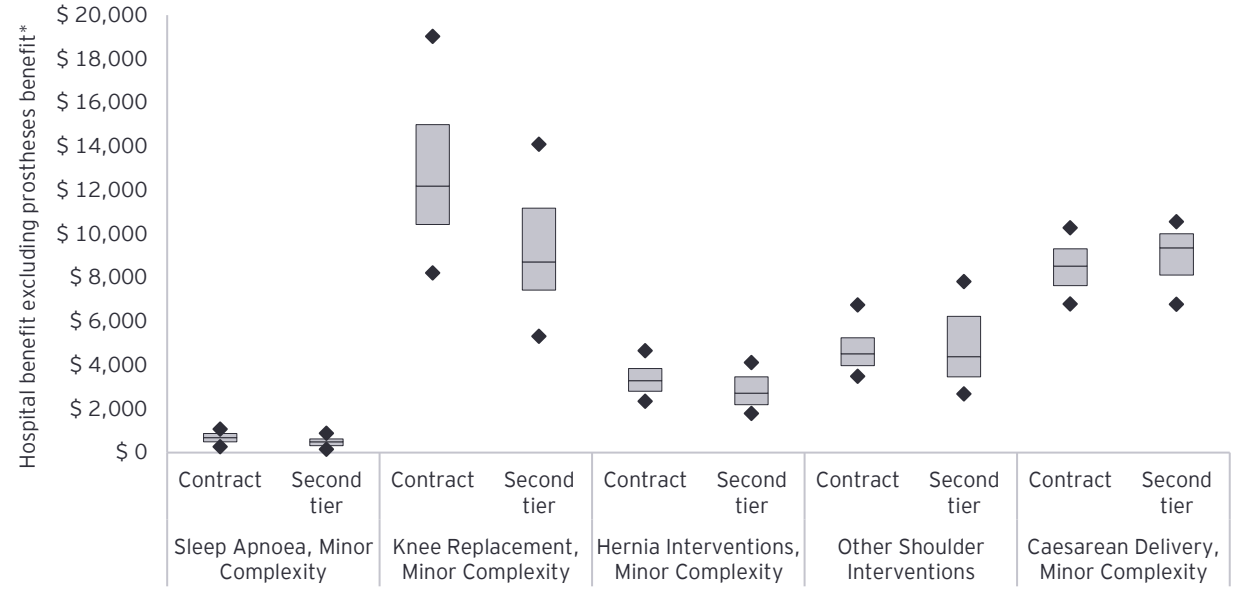


Figure 32: Distribution of hospital benefits (excluding prostheses benefits) paid for the top 5 AR-DRGs in overnight separations



Data source: Pre-processed HCP1 (extracted 14 Sep 2022)

Limits and cautions in interpretation:

- *This chart presents the distribution of hospital benefits excluding prostheses benefits paid by insurers for private hospital separations. It includes benefits paid for separations from FY15 to FY20 (inclusive), inflated to 2022-23 at inflation rates noted in IHACPA NEP Determination reports.*
- *The box represents the range between the 1st quartile and 3rd quartile of benefits, i.e., 50% of separations lie in this box. The diamonds represent the 10th and 90th percentile.*
- *The top AR-DRGs were identified using total volumes from FY15 to FY20 (inclusive) of same-day and overnight separations.*
- *The removed prostheses benefit is based on the PRSTHSS_BNFT_AMT field in HCP1. Some prostheses benefits may be included in the BNDLD_BNFT_AMT and are not able to be identified.*
- *This chart uses AR-DRG version 10.0. Where version 10.0 AR-DRGs were not available, mapping assumptions were made using available versions of AR-DRG. The results are sensitive to the mapping assumptions used.*

Another cause of administrative burden from contracts that has been raised is the range of terms and conditions and reporting requirements. Some of these requirements have been stated to be excessive or, at times, irrelevant, with an example of a hospital being asked for floor plans in negotiations.

There have also been concerns around delays in insurers providing the second-tier default benefit schedules to hospitals, creating cash flow concerns, as well as issues with insurers updating the second-tier default benefit rates after previous queries.

Findings

The current calculation and implementation processes of second-tier default benefits are causing significant administrative burden and costs for both insurers and hospitals, broadly due to the resulting range of benefit amounts for a similar service. A potential opportunity for reform to address this issue is discussed in Section 4.1.1.

There are also significant costs associated with the range of terms and conditions and reporting requirements written into contracts, for which a potential solution is presented in Section 4.2.3.

Transparency and efficiency of rates

There is a view that insurers are able to manipulate the second-tier default benefit rates downwards, by including low rates for services in contracts with hospitals that do not provide that service. There seems to be some evidence of this occurring, with second-tier default benefits below 85% of contracted benefits for all top same-day AR-DRGs (Table 13) and most top overnight AR-DRGs (Table 14). However, these results may also be affected by a difference in the insurers, hospital categories, jurisdiction in which the hospital is located and, for overnight AR-DRGs, length of stay between contracted and second-tier funded separations.

Table 13: Median second-tier hospital benefits excluding prostheses benefits as a percentage of the median contracted benefits for top 5 AR-DRGs for same-day separations

	Same-day separations				
	Chemotherapy	**Colonoscopy, Minor Complexity**	**Complex Endoscopy, Minor Complexity**	**Lens Interventions**	**Other Contacts W Health Services W Endoscopy**
Percentage of second-tier default benefits median over contracted benefits median	77%	65%	69%	82%	73%

Table 14: Median second-tier hospital benefits excluding prostheses benefits as a percentage of the median contracted benefits for top 5 AR-DRGs for overnight separations

	Overnight separations				
	Sleep Apnoea, Minor Complexity	Knee Replacement, Minor Complexity	Hernia Interventions, Minor Complexity	Other Shoulder Interventions	Caesarean Delivery, Minor Complexity
Percentage of second-tier default benefits median over contracted benefits median	72%	72%	83%	97%	110%

***Data source**: Pre-processed HCP1 (extracted 14 Sep 2022)*

Limits and cautions in interpretation:

- *These tables are based on the median levels presented in Figure 31 and Figure 32, respectively.*
- *The limits and cautions associated with Figure 31 and Figure 32 should also be considered in interpreting these tables.*

Further, stakeholders raised questions around the appropriateness of the current hospital categorisation definitions. In particular, there was a view that the bed size criteria were no longer sufficient. This stems from the number of very large hospitals, with the current largest hospital size category being 100 or more beds, as well as small or medium hospitals offering very different services from one another. Related to this point was a suggestion to split the day hospital category based on the type of service provided, given that more than half of private hospitals are currently categorised under Category G (Table 15).

Table 15: Number of hospitals in each hospital category, as at 1 August 2022

	A - Psychiatric	B - Rehabilitation	C - Small	D - Medium	E - Large	F – Large with emergency	G – Short-term
Number of hospitals	45	35	61	48	19	81	350

***Data source**: Private hospital second-tier category list as at 1 August 2022*

It is a legislated requirement that all second-tier default benefit schedules are independently audited by a third-party, and a pre- and post-audit schedule is provided to the Department. However, there is a lack of confidence in these schedules from stakeholders, as there are several different parties auditing the schedules, as well as a call for more transparency in the calculation of second-tier default benefits from each insurer. Although commercial-in-confidence information is a key consideration, there seems to be an opportunity to enable a more consistent application of the legislation.

There have also been concerns around the audit costs incurred by insurers per annum, adding to the cost of the annual second-tier calculation process and ultimately, of a PHI business.

Findings

There are several aspects of the current second-tier calculation process that can lead to second-tier rates that are not efficient, causing under-funding, and create potentially avoidable costs for hospitals and private health insurers, which are passed onto consumers through higher premiums or higher out-of-pocket costs.

A potential Opportunity for reform addressing this issue is explored in Section 4.1.1. There are also opportunities for increased transparency in the second-tier default benefit schedules and therefore, increased confidence in the rates.

Undermining the intent of default benefits through medical contracting

We have heard of possible anti-competitive behaviour in contracting, where insurers restrict payments to doctors to 100% of the MBS fee when the services are performed at a hospital that is not contracted with the insurer. This potentially disincentivises doctors to operate at these hospitals and puts pressure on hospitals to agree on a contract.

Findings

There are ways through which the effectiveness of default benefits in ensuring access to private health services can be compromised. A mechanism for the Department to address such behaviour is presented in Section 4.2.3.

Timeliness of licensing/registration, declaration and accreditation

The time taken for a new hospital to apply for and be granted various requirements affects the funding that can accessed. This is outlined below:

- It takes time from State and Territory licensing/registration to being declared as a hospital by the Department. During this period, hospitals not declared by the Commonwealth are unable to access default benefits or claim PHI benefits from insurers.
- Hospitals must be accredited against the NSQHS Standards to be declared as a hospital by the Department and therefore, be eligible to receive default benefits. This takes up to 60 days after the application is assessed, but this typically occurs more quickly. Consumers can be charged out-of-pocket costs for hospital fees during this period.

Findings

It is reasonable that there are assessment processes for hospitals and that these can take time. However, the lags due to potential inefficiencies in processes and misalignment of timings between licensing/registration, declaration and accreditation may be causing issues, including potentially higher hospital out-of-pocket costs being paid by patients.

3.8 Affordability

It is important that the cost of PHI products and private healthcare is efficient and equitable across all consumers with respect to location and the type of care required.

Affordability was assessed under one Statement.

Table 16: Assessment of current arrangements against affordability

Assessment criteria	Assessment	Our findings
Affordability	Marginally not supported by default benefits	The administrative inefficiencies within the current arrangements add to the costs for both hospitals and insurers, flowing on to costs to the consumer through higher PHI premiums. Due to the small volume of default benefit payments, issues that affect the benefit rates themselves are likely to have a minor impact on premium levels.

3.8.1 Statement 10: The current arrangements support contract negotiations, minimise claim expenses and support lower PHI premiums

This Statement is assessed by drawing upon relevant analysis in previous sections and considering if and how identified issues affect contract negotiations, claim expenses and PHI premiums paid by consumers. It should be noted that the PHI premium paid by a consumer is determined by numerous factors and policies regulating the PHI industry and thus, the siloed effect of default benefits is difficult to determine.

The key issue affecting the costs in the private healthcare sector, and therefore the costs passed onto consumers, is the various sources of inefficiency and administrative burden in the current arrangements, which are outlined in Section 3.7.1. In particular, the process of calculating and applying a wide range of second-tier default benefits, and adhering to and monitoring numerous contract terms and conditions and reporting requirements contribute to the overhead costs of both hospitals and insurers each year.

There are also several issues that may increase the benefit rates themselves, adding to claim expenses and therefore, the PHI premiums charges on consumers, including:

- Second-tier default benefits are tied to higher contract rates, without the corresponding terms and conditions (see Section 3.3.1).
- Second-tier default benefits may act as a price floor, driving up contracted rates (see Section 3.4.1).

However, given the relatively small value of benefits paid through default benefits (Figure 10, page 20), the current arrangements are expected to have a minimal effect on premium levels.

Findings

The administrative burden and inefficiencies associated with current arrangements are likely to have an upward impact on the PHI premium levels paid by consumers. Aspects of the current default benefit arrangements that lead to higher benefits are likely to have a minor impact on premium levels due to the current low usage of default benefits.

4. Opportunities to change default benefits

This Section provides an overview of the possible opportunities for the future of private health insurance default benefit arrangements, which informs our recommendations presented in the following Section.

Eight Opportunities have been developed that are each intended to address different individual issues identified in Section 3 in isolation. These Opportunities specifically target different aspects of the default benefit arrangements – i.e. they relate to either the format of rates, associated rules or the scope of default benefits as shown in Figure 33 and Figure 34 below.

These Opportunities are then combined into two implementable Recommendations for reforming default benefit arrangements, as presented in Section 5.

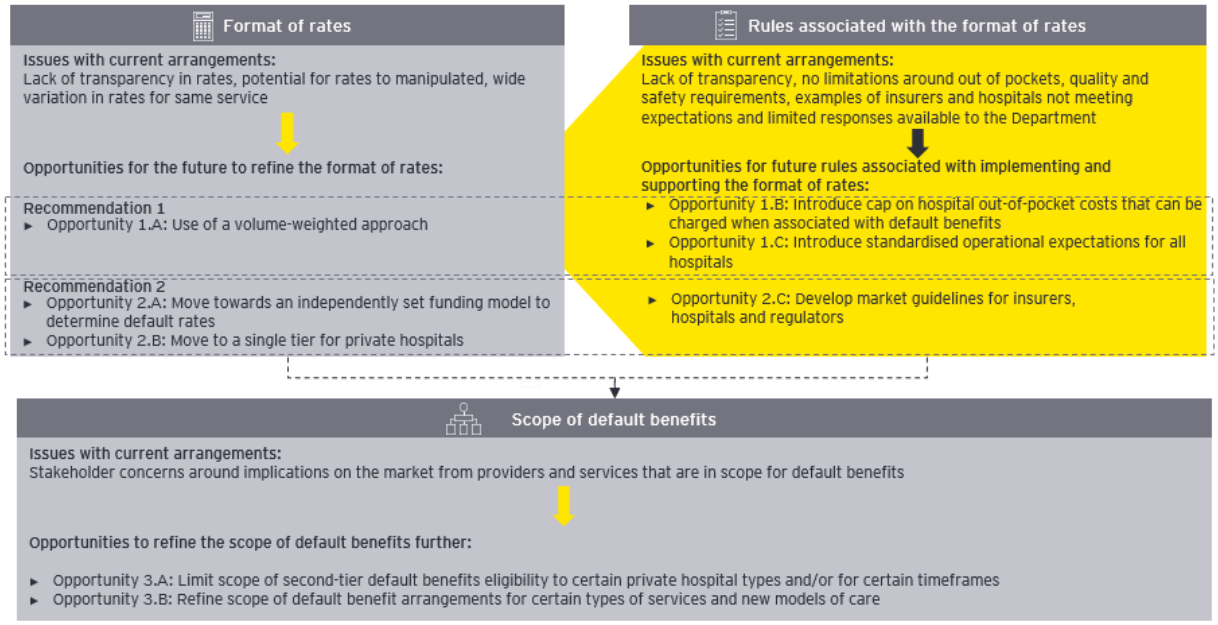
Figure 33: Eight opportunities to make incremental changes to default benefit arrangements

	Opportunities	
Format of rates	1.A	Use of a volume-weighted approach for determining contract averages
	2.A	Move towards an independently set funding model to determine default rates
	2.B	Move to single tier of default benefits for private hospitals
Associated rules	1.B	Introduce cap on hospital out-of-pocket costs that can be charged when associated with default benefits
	1.C	Introduce standardised operational expectations for all hospitals
	2.C	Develop market guidelines for insurers, hospitals and regulators
Scope of second-tier default benefits	3.A	Limit scope of second-tier default benefits eligibility to certain private hospital types and/or for certain timeframes
	3.B	Refine scope of default benefit arrangements to certain service types and new models of care

Each of the Opportunities have been considered against the study Assessment Criteria outlined in Section 2.4.3 to determine if the Opportunity would provide potential improvements, marginal/second order improvements, neutral impacts or potential downside impacts compared with the current default benefits arrangements. Each Opportunity is numbered according to the bundled Recommendation 1 or Recommendation 2 (see Section 5.1) they belong to, with the letters differentiating between multiple Opportunities within the same Recommendation.

To an extent, the eight Opportunities are largely mutually exclusive and so this Section works through each Opportunity separately. However, their design and ultimate effectiveness are somewhat contingent on each other. As such, in implementing reforms to default benefit arrangements, a phased approach that brings together combinations of these Opportunities, and the role and content of the broader PHI reforms, should be considered. This is discussed further in Section 5.1.

Figure 34: Potential reform opportunities



4.1 Format of rates

4.1.1 Opportunity 1.A: Use of a volume-weighted approach for determining contract averages

Opportunity 1.A objectives

The overall objectives of Opportunity 1.A are to

- Reduce the potential risk of manipulation of second-tier default benefit rates and to align them with actual contract rates paid more effectively. This should provide uncontracted hospitals greater confidence in the second-tier default benefit rate and improve their viability in the market, thereby supporting consumer access and choice.
- Support improvements in transparency and consistency around the application of the new formula, consideration could be given to developing specific audit guidelines and a mechanism for enabling the Department direct visibility of underlying calculations.

4.1.1.1 Description

This Opportunity would involve changing the second-tier default benefits calculation methodology to use volume-weighting in second-tier default benefit schedules so that the rates determined reflect actual claim volumes paid through each contract. A specific allowance could be made for new services where there is little or no volume such that this Opportunity does not inhibit the uptake of new and innovative treatments.

This Opportunity will require an adjustment to the formula, detailed within clause 3 of Schedule 5 in the *Private Health Insurance (Benefit Requirements) Rules 2011* (Cth), made under item 3A of the table in section 333-20 of the *Private Health Insurance Act 2007*. Detail on this formula is provided in Appendix D.

In adjusting the formula to reflect paid rates, consultation with the sector is required to understand implications of this adjustment. This consultation would explore the availability and timeliness of input data sources and potential perverse incentives that may arise as a result of the new formula.

An example of an adjustment to the current formula for calculating the volume-weighted average charge for the equivalent episode of hospital treatment by an insurer in each State is as follows:

$$R_j = \frac{\sum_{i=1}^{n}(v_{ji} \times R_{ji})}{\sum_{i=1}^{n} v_{ji}}$$

where:

- j = group of equivalent episodes of hospital treatment under the insurer's negotiated agreements
- i = group of the insurer's negotiated agreements in force on 1 August of the first year with comparable private hospitals in the State
- n = number of the insurer's negotiated agreements in force on 1 August of the first year with comparable private hospitals in the State
- v_{ji} = number of episodes of hospital treatment type j claimed through the negotiated agreement i with admission date from 1 August of the previous year or since the negotiated agreement was in force (whichever is later) to 31 July of the first year. Where the episodes are not based on a full year of claims, the number of episodes should be scaled up to represent an annual amount
- R_{ji} = charge for episode of hospital treatment type j in the negotiated agreement i
- R_j = volume-weighted average charge for episode of hospital treatment type j

A volume threshold could be set so that the new volume-weighted formula only includes negotiated agreements where the total number of episodes for the hospital treatment type claimed through the negotiated agreement exceeds the threshold. Otherwise, where the total number of episodes for the hospital treatment type claimed through the negotiated agreement is lower than the threshold, these episodes are excluded from the calculation of the volume-weighted average charge. The volume threshold is to be determined through further analysis of the consequences of the threshold level.

For services where there is little or no volume (i.e. where the volume threshold is not met for any negotiated agreement), the current simple average formula (as outlined in Appendix D) could continue to apply. Potential scenarios where this may be applied include new services, services recorded under an updated or newly added classification code (e.g. new MBS item numbers or AR-DRG codes), and/or where there has been a recent blanket rate change across all providers with the insurer. Although this leaves some residual opportunity for the manipulation of rates, this approach would allow for stability of the second-tier default benefit rates for services with a lower volume across the sector.

To further support improvements in transparency and consistency created with this Opportunity consideration could be given to developing specific audit guidelines and a mechanism for enabling the Department direct visibility of underlying calculations.

All other rules, such as the definition of a comparable private hospital and calculation adjustment where there are less than 5 comparable private hospitals in a State, would remain the same. This Opportunity requires that hospitals provide claims data to insurers promptly to enable the insurers to calculate the second-tier benefit rates.

This Opportunity would enable the second-tier default benefit rate to be more reflective of actual contracted rates paid. Although it would address a specific issue with the current arrangements, it would have minimal overall impact on the assessment criteria (see Section 4.1.1.2). In Section 4.1.1.3, we recommend Opportunity 1.A be considered as an interim approach to improve the robustness of the calculation of second-tier default benefit rates and immediately improve confidence and consistency across the sector while a longer-term reform opportunity, such as the independently set funding model (Opportunity 2.A), is developed.

4.1.1.2 Assessment

Overall, this Opportunity provides minimal impacts on the current default benefit arrangements, other than potentially marginally improving access to and choice of services.

Legend			
Potential improvements	Marginal/second-order improvements	Neutral	Potential downside impacts

Table 17: Opportunity 1.A rating against assessment criteria

Assessment criteria	Assessment	Detail
Access to and choice of services	Marginal/ Second-order improvements	► The default rates would be more representative of the contracted rates actually paid. In doing so, this should assist in default benefits continuing to support viable service provision and therefore safeguard consumer choice.
Quality and appropriateness of services	Neutral	► No significant impact expected.
Innovation and market dynamics	Neutral	► No significant impact expected.
Equity between consumers of PHI	Neutral	► No significant impact expected.
Integration and adaptability of healthcare system	Neutral	► No significant impact expected.
Practicality	Neutral	► No significant impact expected. Although health insurers would be required to adopt a new calculation methodology, follow specific audit guidelines and make calculations available to the Department, this would be relatively straightforward and have minimal transition costs.
Affordability of PHI products	Neutral	► No significant impact expected.

Supporting analysis

As discussed in Section 3.7.1, the analysis provides some evidence of the potential for the formula for second-tier default rates to be manipulated. The analysis demonstrates that the second-tier default benefits are generally lower than 85% of the contracted rate for the top AR-DRGs for same-day and overnight separations (see Table 13 and Table 14).

Considerations and risks

Regulatory change would be required for this Opportunity (see Section 4.1.1.3), and the marginal gains achieved may not exceed the effort required to implement this change. This Opportunity delivers far fewer benefits to consumers compared to an independently set funding model (Opportunity 2.A) described in Section 4.1.2, however it is considerably faster to implement.

Given the current usage of second-tier default benefits is low overall (see Figure 10), changes to total private hospital payments would be small. Although these anticipated payment changes are small, the impact of this Opportunity on increasing payments through second-tier default benefits should be considered.

Impacts on stakeholders

Private hospitals would receive a different, generally higher, second-tier default benefit rate than the current state, that more closely reflects the actual amounts paid in contracts. The increased second-tier default benefit rate would likely reduce the out-of-pocket payments required to cover hospital costs and improve the viability of hospitals who rely on these payments, particularly those who assert that they currently receive a second-tier default benefit rate significantly below the intended 85% of contracted rates.

Health insurer stakeholders would be impacted through having to adjust their calculation methodology, comply with audit guidelines and make calculations available to the Department. However, this would be a minor administrative change with reasonably low transition costs. Health insurers' second-tier default benefit payments to hospitals may slightly increase but would remain lower than contracted rates.

Impact on consumers

Consumers would benefit from this Opportunity by having greater choice of and access to private hospitals who are supported by second-tier default benefits. This Opportunity should also reduce hospital out-of-pocket costs for consumers, with negligible[52] impact on PHI premiums.

4.1.1.3 Implementation and interactions

Implementation timeframe and activities

Expected timeframes for this Opportunity would be relatively short – perhaps one year from beginning consultation. Legislative changes would have to be made to the calculation methodology detailed in *Schedule 5* of the *Private Health Insurance (Benefit Requirements) Rules 2011*. Movement to the new calculation methodology would have to align with the current timeframes for submission of the new annual second-tier schedules and the Department's annual review of private hospital second-tier categories.[53] Although there would be minimal implementation time, the Department should consider reform around this key date while providing insurers sufficient time to implement the new calculation methodology. Any changes present an opportunity to revisit communication channels and materials to the extent that they efficiently assist compliance.

Interactions with other aspects of the arrangements

As previously mentioned, this Opportunity could be an interim solution whilst an independently set funding model (Opportunity 2.A, see Section 4.1.2) is designed and implemented.

[52] Assuming the change in the calculation methodology has no impact on the contract status between a private hospital and insurer, the impact on total second-tier funded hospital claims cost is estimated to be approximately 10% based on the shortfall to 85% of contracted rates seen in Table 13 and Table 14. This is estimated as an increase of around $15 million in second-tier default benefits, given that insurers pay out $150 million in second-tier default benefits each year (Figure 11). Given that approximately 1.5% of separations are funded through second-tier default benefits (Figure 10), the impact on total hospital claims costs for insurers would be approximately 0.1% (10% x 1.5%). Given that PHI hospital premiums also cover medical and prostheses claims costs, management expenses and insurer profit margins, all of which would be unaffected by this change, it is expected that there would therefore be negligible impacts on PHI premiums paid by consumers.

[53] This annual review must be undertaken to specific regulatory timeframes for 1 September implementation by the PHI sector, ensuring appropriate PHI benefits for consumers.

Additionally, introducing a cap on hospital out-of-pocket costs (Opportunity 1.B, see Section 4.2.1) could be introduced alongside this Opportunity, to support consumers in realising the benefits when higher second-tier default benefit rates are paid to private hospitals.

4.1.2 Opportunity 2.A: Move towards an independently set funding model to determine default rates

Opportunity 2.A objectives

The overall objective of Opportunity 2.A is to provide consumers with confidence that the safeguard level of default benefits supports adequate funding for safe and quality care. It would achieve this by improving the consistency and robustness of second-tier default benefit rates, reducing inefficiencies associated with wide price variation for similar services, and further reducing the administration costs associated with default benefit rates.

4.1.2.1 Description

This Opportunity involves an alternative approach to determining the default benefit rates. There are three key aspects to this Opportunity that differ from the current arrangements:

- **Rates set by an independent body**: Currently, the second-tier default benefit rates are calculated by each individual insurer, whilst the minimum benefits are defined in legislation. This Opportunity proposes that the determination of default benefit rates is conducted by an independent body.

- **Funding model framework**: The framework for determining default benefit rates may take on aspects similar to the NEP model which underpins activity-based funding for public hospital services. A benchmark price, similar to the NEP, would be determined, alongside weighted activity units for services. This price would represent accommodation and theatre fees to reflect the current second-tier default benefit rates, but could be expanded beyond these fees if appropriate. There are a number of alternative approaches to calculating this benchmark price, including:

    - A cost-plus approach using private hospital cost data, however this presents the challenge of determining a profit margin to be applied to the cost, or

    - A benchmark price based on existing contracted rates between hospitals and insurers, or

    - A blend of the two.

- This benchmark price and weighted activity units could then be used to determine second-tier default rates, and could also be extended to calculating minimum benefit rates. The determination of the second-tier default should be such that the default rates continue to incentivise contracting between hospitals and insurers.

- The types of services priced under this model would reflect those covered under the current default benefit arrangements. However, in combination with Opportunity 2.C (see Section 4.2.3) the funding model could be designed to factor in all potential models of care, including HITH, and therefore could better support innovative models of care.

- **Methodology**: If the benchmark price and accompanying weighted activity units are calculated based on the actual costs of providing services, this funding model enables the calculation of adjustments based on legitimate and unavoidable variations in the cost of care. Similar to the

IHACPA's NEP model,[54] these adjustments should be based on patient- and clinical-related characteristics rather than provider-related characteristics wherever practicable.

- If the revised methodology allows sufficient confidence that the default rates provide adequate funding to support the provision of safe and quality care, there should be less need for private hospitals to charge out-of-pocket costs, and so the cap from Opportunity 1.B (see Section 4.2.1) could be further revised.

4.1.2.2 Assessment

This Opportunity provides many potential improvements to the current default benefit arrangements. The efficiencies identified in the assessment to the immediate benefit of insurers and/or hospitals, but can be reasonably assumed to flow on to benefit the consumer through the affordability assessment. Practicality must be acknowledged due to the high cost of transition and the many considerations for implementation.

Legend			
Potential improvements	Marginal/second-order improvements	Neutral	Potential downside impacts

Table 18: Opportunity 2.A rating against assessment criteria

Assessment criteria	Assessment	Detail
Access to and choice of services	Potential improvements	► A transparent rate would be immune to changes in contracting practice that should not impact default benefits. This should assist in default benefits continuing to support viable service provision. ► Published rates support providers in providing accurate information for consumer Informed Financial Consent (IFC).
Quality and appropriateness of services	Marginal/ Second-order improvements	► Potential for marginal improvements in service value through payment bundling structures to drive better value services for consumers, and ensure adequate funding to ensure safe and quality services can be provided.
Innovation and market dynamics	Potential improvements	► Reduced price variation for default rates which should improve efficiency – see Figure 31 and Figure 32. ► The inefficiencies and limitations of the NPBC's current procedure banding processes, as identified in Section 3.4.1, would no longer be relevant if a benchmark price were set by another independent body. ► Contracting efficiency would be improved by creating a starting point for negotiations based on more transparent information. ► Potential to develop suitable approach to fund HITH services and other innovative care models.
Equity between consumers of PHI	Potential improvements	► With sufficient confidence that the default rates provide adequate funding to support the provision of safe and quality care, there should be less need for private hospitals to charge out-of-pocket costs, and so the cap from Opportunity 1.B could be further revised.
Integration and adaptability of healthcare system	Marginal/ Second-order improvements	► This Opportunity could align with broader reforms and studies within the sector, including potentially providing bundled information for consideration in prostheses reform, and use of an independent agency collecting sector data as current alignment to the direction of prostheses reform and how funding in the public system is determined. ► This approach would align with the existing NEP funding model used for the public hospital system. The consistency in approaches and availability of similarly structured comparable cost data between public and private hospitals should enable further analysis and monitoring to deliver system level efficiencies.
Practicality	Potential improvements	Transparency and consistency:

[54] Independent Health and Aged Care Pricing Authority, 2021. Pricing Framework for Australian Public Hospital Services 2022-23. Available at: www.ihacpa.gov.au/resources/pricing-framework-australian-public-hospital-services-2022-23

Assessment criteria	Assessment	Detail
		► Second-tier default benefit rates would be published providing greater transparency across the sector, which would improve contracting efficiency. ► Price variation and opportunities for the manipulation of second-tier default benefit rates allows providers more certainty towards operationalisation of their service offerings. Administrative efficiency: ► Having a single schedule of default benefit rates would be more efficient administratively. ► Updated prices would be made available with sufficient lead time prior to implementation. ► The contract negotiation process would require less resources. **However, this reform Opportunity is complex to develop with significant costs of transition. See below for considerations.**
Affordability of PHI products	Marginal/ Second-order improvements	► Could provide marginal impact on affordability via downstream effect of improvements to contracting efficiency providing lower administration costs that could be passed onto consumers.

Supporting analysis

As discussed in Section 3.7.1, there is evidence of price variation for similar services in both contracted rates and second-tier default benefits (see Figure 31 and Figure 32, page 59). This points to the administrative burden of implementing a wide range of prices depending on the hospital and insurer, as well as pricing inefficiencies.

As part of the illustrative analysis for this Opportunity, we conducted an indicative comparison of:

► Private patient funding from current arrangements of contracted and default benefits.

► Public patient funding through the IHACPA's current NEP model (NWAU(22)).

This analysis estimates the separation-level funding impacts if the funding amounts under the current IHACPA model for public patients were applied to fund privately insured patients. The results of this analysis can be found in Appendix F.4. It shows that the current wide range of prices for similar services would be significantly reduced.

The impacts of an independently set funding model will depend on the considerations listed above and hence are likely to differ from this application of IHACPA's NEP model in its current form. Should this Opportunity be pursued, we recommend that this analysis is refreshed with up-to-date data to inform how the design of the independently set funding model may take certain aspects of the current NEP model.

Considerations and risks

This Opportunity is complex in nature, with a number of considerations that will need to be worked through prior to implementation. These include, but are not limited to:

► **Data collection**: How cost and/or contracted price data is collected from the sector, including potential legislative changes required to collect accurate and timely data from hospitals and/or insurers, and consideration of how commercial-in-confidence data is treated and shared. The collection of cost data can build upon IHACPA's collection for the private sector National Hospital Cost Data Collection.[55] As of 2021 in Round 23, based on FY2018-19, the voluntary

[55] Independent Health and Aged Care Pricing Authority, 2021. National Hospital Cost Data Collection: Private Hospital Report: Round 23 (Financial year 2018-19). Available at: www.ihacpa.gov.au/sites/default/files/2022-02/National%20Hospital%20Cost%20Data%20Collection%20%28NHCDC%29%2C%20Private%20Hospital%20Report%2C%20Round%2023%20%28financial%20year%202018%E2%80%9319%29.pdf

collection covered 108 overnight private hospitals and represented 65% of private hospital activity.

- **Classification systems**: The appropriate use of classification systems in the design of the funding model. There are different structures in existing contractual arrangements between hospitals and insurers, including variation of benef its by MBS, DRGs, procedure bands defined by the NPBC, clinical categories, and step-down rates. The design of the funding model should consider the use of different classification systems and the extent to which these are then aligned to these existing contractual arrangements.

- **Costing methodology**: Consistency of cost allocation methods between hospitals and the extent that the current costing processes align to the Australian Hospital Patient Costing Standards.

- **Determination of benchmark price**: How the benchmark price is determined, for example through a cost-plus approach, using existing contracted rates, or a blended approach between the two. If a cost-plus approach is used, margin assumptions would need to be developed and agreed.

- **Scope of funding and costs**: Currently the second-tier default benefit rates are based on the charge for hospital treatment, and do not include charges relating to PHI medical benefits and prostheses. Consideration of the scope of costs, including capital costs, and other funding sources should be taken into account when determining the benchmark price and default benefit rates under this alternative approach.

- **Adjustments to account for different characteristics**: There are a number of decisions to be made as to which factors should be used for determining the adjustments to the default benefit rates, including provider- and patient-level characteristics.

- **Frequency**: The frequency in which the funding model is updated should be considered, weighing up the benefits of updating frequently such that the rates are based on timely input data, compared to the administrative implications on all stakeholders, particularly in the provision of detailed cost data, which is not currently collected from all private hospitals on a regular basis.

Stakeholder views

An independently set funding model received general support from each stakeholder group as a concept. There were differing views regarding the overall feasibility and specifics in implementation. However, both private hospital and insurer stakeholders indicated some support for this potential reform Opportunity with some shared views on the perceived benefits including a reduction in administration associated with calculating and applying the second-tier default benefit rates, improved transparency, and improved consistencies in payments.

Although all stakeholder groups recognised benefits, some individual private health insurers and private hospitals could be worse off or have higher transition costs under this Opportunity compared to others. In transitioning from a wide range of second-tier default benefit rates to a narrower range, private hospitals at the top end of the current range may see a reduction in second-tier default benefit rates received. Consultation to understand the impact on different stakeholder groups would be needed to consider if a focussed transition effort would be required for certain stakeholders.

Impact on consumers

Consumers should be the ultimate beneficiaries from publishing more data about the costs of services. Consumers would benefit through the efficiency and administration cost reductions that would ultimately lead to lower PHI premiums and hospital out-of-pocket costs. They would also

experience more choice between and access to service providers with the second-tier default rates more closely reflecting actual viability.

4.1.2.3 Implementation and interactions

Implementation timeframe and activities

From the consultation and scoping stage, the rough timeline for this Opportunity could be three to five years. Due to the complexity of this Opportunity, it is important that sufficient time and support is provided to assist private hospitals and private health insurers with the transition process. This may involve a possible shadow period whereby the current arrangements would continue and the new independently set funding model would be fully operational and available to stakeholders (but without being applied to determine the new second-tier default benefits in practice).

Should this Opportunity be pursued by the Department, we anticipate that the key activities in developing the model include consultation with the sector, collection of data and data analysis, including a refresh of the analysis referenced above (Supporting analysis) with up-to-date data. The development of the model should consider the possible flow-on effects on contracting and demand in the public system. In addition to the development of the funding model, the future operating model should be established, with consideration of the administrative and legal implications of the model, legislative changes, resourcing and funding for the independent body, and annual processes associated with the model.

Interactions with other aspects of the arrangements

This Opportunity could be implemented alongside other reform Opportunities presented in this report. Given the relatively long implementation and development timeline, the inefficiencies present in the current arrangements would be present during this period. All of the interactions with other reform Opportunities are captured in Section 5.1.

As such, in the meantime, shorter-term Opportunities that address the potential for manipulation of the second-tier default benefits rates through contracting (Opportunity 1.A) and put a cap on hospital out-of-pocket costs (Opportunity 1.B) could be implemented. If and when this Opportunity is implemented, it would then replace Opportunity 1.A, and the need for, and application of, the cap in Opportunity 1.B should be reconsidered.

The sector wide impacts of the model mean that implementing this Opportunity alongside other aspects that would reduce the scope of default benefits, such as Opportunities 3.A and 3.B, might be counterproductive. Successful implementation will require a degree of cross sector buy-in and limiting default benefits to certain providers or services will remove incentives for these stakeholders to engage in the process and to provide data.

The impact on minimum benefits (Opportunity 2.B) will also need to be considered in conjunction with this Opportunity. Minimum rates could be maintained but there is potential for minimum rates to be based on a lower weighting of the benchmark price, maintaining a similar two-tier structure to that which currently exists.

The effectiveness of introducing standardised operational expectations for all hospitals (Opportunity 1.C) also has an impact on this Opportunity. It should reduce and improve consistency in hospital administration costs that would feed into the cost base for the funding model.

4.1.3 Opportunity 2.B: Move to a single tier of default benefits for private hospitals

Opportunity 2.B objectives

The overall objective of Opportunity 2.B is to create clarity around the purposes of minimum benefits, align them with these purposes, and develop a transparent approach to the determination of minimum benefits. The intended purposes of minimum benefits are to provide choice to PHI consumers by funding private patients in public hospitals and to protect consumers by providing a level of benefit for private hospital services where their product only offers restricted benefits.

4.1.3.1 Description

Minimum benefits are the mechanism that funds both private patients in public hospitals and restricted benefits. This proposed Opportunity would clarify the purpose of minimum benefits by retaining their use for both private patients in public hospitals and for restricted benefits on certain PHI products. It would remove their rare use in funding non-second-tier eligible private hospitals, noting that the minimum benefit rates are lower than the second-tier default rates.

This Opportunity retains the same approach for setting minimum benefit rates in the short term with a shift to utilising the independently set funding model for private hospitals when available (Opportunity 2.A, see Section 4.1.2).

The funding of private patients in public hospitals is a policy decision that has implications for government stakeholders, in particular the jurisdictions, with the intention that it provides consumers additional choice and increases the value proposition of PHI more broadly. Allowing PHI products to offer restricted benefits so that they meet product classification criteria is intended to support affordable access to important service types.

The effectiveness and future direction for both of these policies should be considered in their own right, with implications on minimum benefits as a consequence. The broader purpose of allowing PHI policies to only offer restricted cover for certain service types and meet product classification criteria should be considered, however is outside the scope of this study. The low level of cover that they offer for these services may lead to significant hospital out-of-pocket costs for consumers.

4.1.3.2 Assessment

Overall, this Opportunity provides minimal impacts on the current default benefit arrangements, other than potentially improving the integration and adaptability between the public and private systems.

Legend			
Potential improvements	Marginal/second-order improvements	Neutral	Potential downside impacts

Table 19: Opportunity 2.B rating against assessment criteria

Assessment criteria	Assessment	Detail
Access to and choice of services	Neutral	► No significant impact expected. Maintains choice for consumers to be funded privately in public hospitals and to access restricted services.
Quality and appropriateness of services	Neutral	► No significant impact expected.
Innovation and market dynamics	Neutral	► No significant impact expected.

Assessment criteria	Assessment	Detail
Equity between consumers of PHI	Neutral	► No significant impact expected.
Integration and adaptability of healthcare system	Marginal/ Second-order improvements	► This approach would align with the existing NEP funding model used for the public hospital system. The consistency in approaches between public and private funding for public hospital services would be more intuitive and could provide useful comparison.
Practicality	Marginal/ Second-order improvements	► Short-term transition costs of moving administration systems and processes to the new structure. ► Potentially further administrative savings through if the structure aligns with the existing NEP (for public hospitals) and second-tier default benefits (for private hospitals processing restricted benefits). ► Removes the additional complexity in the rules for non-second-tier eligible private hospitals also accessing minimum benefits.
Affordability of PHI products	Neutral	► No significant impact expected.

Considerations and risks

A consequence of changing minimum benefits to link to the independently set funding model (Opportunity 2.A) is that it could enable funding towards both theatre fees and accommodation.

Commonwealth, State and Territory stakeholders also need to be considered, as changes to the minimum benefit would have the most impact to this group of stakeholders. Although the private patient accommodation and neutrality adjustments should mitigate any changes made to minimum benefits, it is possible the proportions of funding contributed by Commonwealth and State and Territory governments could shift. It is also possible the total funding received by public hospitals towards private patients is impacted.

Removing minimum benefits from non-second-tier eligible hospitals could be problematic if there remains a gap/lag in the processing time for second-tier eligibility to be granted.

Impacts on stakeholders

The key stakeholders impacted by changes to the minimum benefit are public hospitals and private hospitals offering services specified as restricted benefits, such as palliative care, rehabilitation and mental health. However, impacts would be minimal assuming a percentage of the benchmark price is selected that is similar to the current minimum benefit and the private patient adjustments would reduce any further funding variances. It is essential that, in the development of this Opportunity, these stakeholders are engaged and involved.

Impact on consumers

Some regional and rural areas do not have access to a local private hospital, and in these areas using minimum benefits in public hospitals is an important mechanism to support consumers obtaining value from their PHI products. This Opportunity also supports consumer access and choice via funding for private patients in public hospitals and for restricted benefits.

4.1.3.3 Implementation and interactions

Implementation timeframe and activities

Changes to minimum benefits would be made following the adoption of the independently set funding model (Opportunity 2.A). However, consultation and an understanding of the potential impacts, in particular on public hospital funding, would need to occur prior to implementation.

Interactions with other aspects of the arrangements

As noted above, changes to minimum benefits would be made as a consequence of the independently set funding model (Opportunity 2.A).

As noted above, removing minimum benefits from non-second-tier eligible hospitals could be problematic if there remains a gap/lag in the processing time for second-tier eligibility to be granted. As such, this change would need to be considered in parallel with reforming the requirements on hospitals (Opportunity 1.C).

4.2 Associated rules

The rules associated with the format of rates outline the factors that need to be considered when implementing the format of rates. These include licensing/registration, accreditation requirements aligned with national safety and quality standards (NSQHS), and contract structures, and are outlined in further detail in the remainder of this Section.

4.2.1 Opportunity 1.B: Introduce cap on hospital out-of-pocket costs that can be charged when associated with default benefits

Opportunity 1.B objectives

The overall objective of Opportunity 1.B is to protect consumers from the high hospital out-of-pocket costs that may be charged by some second-tier funded providers.

4.2.1.1 Description

This Opportunity will provide a cap on hospital out-of-pocket costs that private hospitals can charge when using default benefits.

The exact design of this mechanism will be reliant on the format of rates. Using the existing format of rates, whereby the default benefit paid to hospitals is 85% of the contracted rate, the hospital out-of-pocket costs could be capped at 15% of the contracted rate, providing out-of-contract facilities with up to 100% of the contracted rate. This percentage would have to be further analysed to determine whether it appropriately supports consumer choice and access.

Note that medical out-of-pocket costs would remain uncapped as specialist charges are subject to legislation unrelated to default benefit arrangements.

If Opportunity 2.A, an independently set funding model to determine default rates discussed in Section 4.1.2, is used, then the cap on hospital out-of-pocket costs could be the residual between the benchmark price and default rates. This could be considered as part of the design of Opportunity 2.A.

4.2.1.2 Assessment

This Opportunity provides a neutral to positive change to the current default benefit arrangements.

Legend			
Potential improvements	Marginal/second-order improvements	Neutral	Potential downside impacts

Table 20: Opportunity 1.B rating against assessment criteria

Assessment criteria	Assessment	Detail
Access to and choice of services	Potential Improvements	► Can serve as a safety net for consumers and supports financial access. ► Could impact consumer choice. Should be wary if it means some providers become less viable. Some consumers do not mind paying a bit more to have choice to access their local provider.
Quality and appropriateness of services	Neutral	► No significant impact expected.
Innovation and market dynamics	Neutral	► No impact – some hospital out-of-pocket costs still associated with default benefits should mean that contracting remains the preferred approach for both parties if agreeable rates can be found.
Equity between consumers of PHI	Neutral	► No significant impact expected.

Assessment criteria	Assessment	Detail
Integration and adaptability of healthcare system	Neutral	► No significant impact expected.
Practicality	Neutral	► No impact longer-term on payment systems etc. ► Potentially minor transitional changes for hospitals in ensuring. compliance with updated rules.
Affordability of PHI products	Neutral	► No significant impact expected.

Supporting analysis

We previously compared the incidence and the amount of hospital out-of-pocket costs paid by patients, excluding any front-end deductible, under contracting and second-tier default benefit arrangements in Figure 23. A higher proportion of separations under second-tier default benefits pay hospital out-of-pocket costs. However, where paid, contracted separations pay higher hospital out-of-pocket costs on average. There are limitations in the analysis of HCP1 data in identifying the contract status of separations, which impact the robustness of these statistics. Notwithstanding these analysis results, there are benefits to capping hospital out-of-pocket costs for consumers.

Considerations and risks

Hospital stakeholders have raised some concerns about a cap on hospital out-of-pocket costs that is related to default benefits, including:

- Default benefits are determined based on historic contracted rates, which means that, due to ongoing cost inflation, the total charge to remain viable may need to be higher in the future.
- Being paid through default benefits is an indication that the contracted rates are seen to be insufficient to the hospital and so, again, the total charge to remain viable may need to be higher.

However, the hospital's perspectives of its requirements needs to be balanced against the consumers' needs and whether it is reasonable for a hospital to charge the consumer potentially high and unregulated hospital out-of-pocket costs in a situation where it has received regulated benefit amounts. Further analysis and consultation should be conducted to understand potential implications of these suggestions and whether they are reasonable for the consumer.

It should also be acknowledged that some consumers might be willing to pay relatively high hospital out-of-pocket costs in select situations to access their preferred hospital. For example, a local hospital may be preferred over one that requires significant travel time. In addressing this Opportunity, it is important to consider whether it might push some hospitals out of the market and hence reduce choice for the consumer. Given the low frequency of high hospital out-of-pocket costs, this is unlikely to be a significant concern.

Impacts on stakeholders

Insurers are broadly in favour of this reform Opportunity because they have no way of limiting hospital out-of-pocket costs for members who receive services from uncontracted providers (who receive second-tier default benefits).

Hospitals could be negatively impacted if the default benefit and the capped hospital out-of-pocket cost does not result in a benefit amount that sufficiently supports the viability of their business.

Impact on consumers

The small number of consumers who are charged large hospital out-of-pocket costs would immediately benefit from a cap on hospital out-of-pocket costs. However, there could be negative downstream impact on access to and choice of services if the caps are unsustainable for hospitals.

4.2.1.3 Implementation and interactions

This Opportunity would be relatively straightforward to implement on a process level, as it could be aligned with adjusting the formula in Opportunity 1.A (see Section 4.1.1). The impact on the system should be taken into consideration and worked through via consultation with providers, which could impact timelines.

Interactions with other aspects of the arrangements

It is recommended that this Opportunity is only implemented if Opportunity 1.A is implemented. Implementing this Opportunity *without* Opportunity 1.A (i.e. if it was implemented with the current arrangements, whereby a hospital out-of-pocket cap based on a percentage of the contracted rate was implemented) would be problematic if the second-tier rate was not an accurate representation of the contracted rate due to potential manipulation.

This Opportunity could be implemented while Opportunities 2.A and 1.C are being developed and implemented. Once these Opportunities are developed and implemented, hospital out-of-pocket costs could be capped further or completely disallowed.

4.2.2 Opportunity 1.C: Introduce standardised operational expectations for all hospitals

Opportunity 1.C objectives

The overall objective of Opportunity 1.C is to improve consistency in operational expectations between private hospitals who are supported by second-tier default benefits and contracted hospitals via the private hospital declaration process. This Opportunity would create greater consistencies for consumers and introduce administrative efficiencies to reduce costs for insurers and hospitals.

4.2.2.1 Description

This Opportunity would involve standardisation of hospital operational expectations via the private hospital declaration process to improve consistency between hospitals with high utilisation of second-tier default benefits and contracted hospitals. This option would involve:

- **Introducing better operational practice expectations** such as mandating the use of national digital health infrastructure, such as Digital Health Records, or participation in nationally recognised clinical registers.

- **Reducing inefficient and duplicative contract terms.** Outside of the NSQHS standards, there are no additional requirements on hospitals claiming second-tier default benefits. Conversely, contracted hospitals have additional requirements placed in their contracts with health insurers. These requirements often relate to safety and quality, such as hospital re-admission rates, which can create additional and potentially duplicative reporting, increasing hospital administrative burden. Private hospital stakeholders have stated that the different requirements used by insurers across contracts creates duplicative effort without any value add to consumers or the quality of care.

- **Improving the timeliness, quality and consistency of data reporting**, including, but not limited to reporting required for HCP and PHDB datasets.

- **Updating the private hospital declaration process.** Including the standardised hospital expectations in the private hospital declaration process ensures consistency between hospitals with high utilisation of second-tier default benefits and contracted hospitals

These requirements would apply across all hospitals, regardless of whether they are funded through default benefits or contracts. This should support a more efficient private healthcare sector, to the ultimate benefit of consumers.

This Opportunity would aim to create greater alignment within reporting, data provision, audit requirements and processes across private health.

Note that Opportunity 2.C (Section 4.2.3), develop market guidelines for and in consultation with insurers, hospitals and regulators, is intended to align with and build upon this Opportunity in order to drive better-practice and support innovation.

4.2.2.2 Assessment

This Opportunity would potentially provide marginal improvements to access, affordability, equity and integration of the private and public system. There would be greater improvements to the current arrangements in quality and the practicality of the benefits.

Legend			
Potential improvements	Marginal/second-order improvements	Neutral	Potential downside impacts

Table 21: Opportunity 1.C rating against assessment criteria

Assessment criteria	Assessment	Detail
Access to and choice of services	Neutral	► Marginal/second-order impacts from other benefits.
Quality and appropriateness of services	Marginal/ Second-order improvements	► Standardising hospital operational expectations will limit variations in the operations between hospitals, which may improve consumer experience overall.
Innovation and market dynamics	Neutral	► Competition and market dynamics would be maintained as insurers would still be able to pay more for higher than minimum expectations through contracting.
Equity between consumers of PHI	Marginal/ Second-order improvements	► Creating consistency in hospital operations would improve the equity between consumers across all private hospital providers.
Integration and adaptability of healthcare system	Marginal/ Second-order improvements	► This Opportunity could improve integration through providing the opportunity to create more alignment between the operational expectations across the healthcare system.
Practicality	Potential Improvements	► Hospitals' operationalisation of second-tier default benefits and contract funding should be significantly more streamlined due to reducing inefficient and duplicative contract terms. ► Ongoing benefit of a simplified contracting and negotiation process. ► Contracts would need to be updated to remove inefficient and duplicative contract terms.
Affordability of PHI products	Marginal/ Second-order improvements	► Although hospital administration costs could be reduced as they relate to processing insurer payments, this is a relatively small component in contributing towards overall PHI product cost.

Considerations and risks

A key concern of stakeholders is that second-tier default benefits have been paid to private hospitals, particularly new facilities. Stakeholders have noted that it is possible for private hospitals to have lacked satisfactory operational practices, and still access second-tier default benefits. Standardising operational expectations for all hospitals, including new hospitals who have interim accreditation (see Table 7) could alleviate these concerns. This reform Opportunity would implement new rules to mitigate these unintended consequences of the current system and prevent providers who do not meet the standardised operating procedures from being able to operate and receive second-tier default benefits. Existing eligibility requirements define the access of hospitals to funding but impose no minimum requirements around operating.

Hospital stakeholders stated that, although safety and quality incentives and requirements can be placed on hospitals in contract terms, the actual safety and quality outcomes in contracts that are in addition to the NSQHS could be contingent on the medical practitioners. In some instances, hospitals do not want to intervene or control the autonomy of clinicians to deliver the services or procedures they see most fit. As a result, additional safety and quality outcomes in contracts are not completely in their control.

Impacts on stakeholders

Standardising operational expectations across all hospitals and reducing inefficient and duplicative contract terms will impact the current approach of the negotiation processes between insurers and private hospitals. Under this Opportunity, insurers would still be able to differentiate through safety and quality conditions within contracts, but some other areas of differentiation that are currently included in contracts, such as individualised data and reporting requirements, would be made obsolete.

Some private hospitals may face more stringent operational requirements than currently and therefore incur additional costs.

Impact on consumers

Standardised operational practice expectations, reducing inefficient and duplicative contract terms, and improving the timeliness, quality and consistency of data reporting should support a more efficient private healthcare sector, to the ultimate benefit of consumers. Additionally, greater standardisation across operational requirements would provide more consistency to the consumer experience (such as enabling consumers to access information via nationally recognised clinical registers).

4.2.2.3 Implementation and interactions

Implementing standardised operational expectations for all hospitals will require substantial stakeholder consultation, which will contribute to a mid-range transition period. The implementation of this Opportunity will:

- Strongly rely on industry working together to develop a standardised set of expectations and definitions.
- Require substantial stakeholder consultation.
- Require an analysis of other health sectors both nationally and internationally to identify best practice health service contracting principles and operational expectations.
- Require a transition period for hospitals to comply with the operational expectations.

Insurers and hospitals could remove inefficient and duplicative contract terms, as contracts are renewed after implementation (as existing/new contracts usually have a term equal to, or over, three years), however this would unlikely be required under the standardised operational expectations.

The implementation of this Opportunity could occur iteratively.

Interactions with other aspects of the arrangements

This reform Opportunity could provide further value to developing market guidelines for insurers, hospitals and regulators (Opportunity 2.C (Section 4.2.3)) to drive better-practice and support innovation.

4.2.3 Opportunity 2.C: Develop market guidelines for insurers, hospitals and regulators

Opportunity 2.C objectives

The objective of this Opportunity is to develop market guidelines informed by insurers, hospitals and regulators, that supports contract efficiency by promoting common terminology, definitions and performance measures, drive broader insurer-funding of innovative services such as HITH where appropriate by describing a framework for contract negotiations and promote fair and competitive contracting behaviour on both insurer and hospital sides. The guidelines would provide the Department with the capability to apply a graduated response to any problematic behaviours identified from the guidelines through appropriate Commonwealth. This would enable more timely responses to issues and more appropriate and relevant actions to amend them.

4.2.3.1 Description

The nature of contracting in PHI is complex and ever-evolving as new business practices and trends emerge. This has caused large administrative burdens on both hospitals and insurers in negotiating and adhering to contracts. The complexity of contracting in PHI also creates an environment where it is difficult for legislation to keep pace and cover all eventualities.

The development of market guidelines would contribute towards better-practice and alignment in approaches for contracting, including in areas related to operations such as reporting, definitions for measures of quality/clinical classifications (including Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs)) and contract structures.[56] Currently there is variation between metrics used in different health insurer contracts to promote improved customer outcomes. Aligning these metrics to an industry-agreed better-practice model would retain contract-driven incentives while reducing the administrative burden for private hospitals.

The market guidelines could include the following items within contracts between insurers and hospitals, which are intended to address the issues identified in Section 3.7.1:

- The patient classification system to be used in contracting.
- Costs included within benefits, and standards for bundling.
- Accommodation benefits by service and/or care type, length of stay, and type of rooms.
- Theatre benefits.
- Differences applicable by hospital category or State/Territory.

[56] The terms within the classification structures themselves would not be standardised, insurers and hospitals within the working group would need to agree on these.

In addition to the structure of contracts, the guidelines would create high-level rules around the contracting process, providing guidelines for mediation, timings and cut-offs. Describing a clearer framework around the contracting process and structures for innovative services could assist hospitals and insurers in negotiating a market solution to HITH and provide more widespread funding and availability of these services for consumers.

There have been specific issues of varying severity that negatively impact the competitiveness and effectiveness of the private health industry. These include insurers using contracting with medical practitioners to disincentivise them operating in second-tier funded facilities, which arguably undermines the intent of default benefits in supporting consumer access, as described in Section 3.7.1, or hospitals not meeting reporting obligations through the provision of sufficiently timely and accurate HCP and PHDB data.

At the same time, the Department only has one regulatory response available to private hospital non-compliance, which is to revoke second-tier eligibility completely.

This reform proposes the creation and implementation of market practice guidelines, developed in collaboration between insurers and private hospitals. A cross-industry working group with equal representation could provide advice on any key anti-competitive and non-compliant behaviours that should be addressed through the guidelines, as well as defining the range of responses that should be available to the regulator for each issue that is identified. The guidelines developed would align with existing regulatory bodies such as the Australian Competition and Consumer Commission (ACCC), to ensure no duplication while providing guidance more specific to the sector.

The Department's regulatory responses could be described in a regulatory and enforcement policy through appropriate Commonwealth legislation, with the market guidelines identifying situations where the Department could choose not to enforce any regulatory action. For example, if there were unforeseen system issues, the Department could choose to not take regulatory action after a written application has been made.

A useful model of comparison to this Opportunity would be the State Insurance Regulatory Authority's (SIRA) motor accident guidelines: market practice and business plans.[57] These guidelines are intended to correct anti-competitive behaviours as they emerge. In the private healthcare sector, a similar set of guidelines could be developed by the Department in collaboration with private hospitals and private health insurers. Guidelines provide a faster and more agile way for any anti-competitive behaviour to be identified and non-compliant behaviour to be responded to when compared to legislation. This Opportunity will require understanding the current standards and guidelines that exist for the key gaps to be targeted.

The effectiveness of the SIRA guidelines is underpinned by its defined principles and requirements. These include the guiding principles of good faith, transparency, non-discrimination and accessibility. Each of these principles could be considered when weighing up the behaviour of insurers and hospitals during interactions.

4.2.3.2 Assessment

This reform Opportunity provides marginal improvements to the current default benefit arrangements.

Legend			
Potential improvements	Marginal/second-order improvements	Neutral	Potential downside impacts

[57] SIRA. 2022. Motor Accident Guidelines. Available at: www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/motor-accident-guidelines – see parts 2 and 3

Table 22: Opportunity 2.C rating against assessment criteria

Assessment criteria	Assessment	Detail
Access to and choice of services	Neutral	► No significant impact expected.
Quality and appropriateness of services	Marginal/ Second-order Improvements	► Should strengthen the framework that supports the delivery of quality and appropriate services.
Innovation and market dynamics	Potential Improvements	► Should generally support competition and improve consumer experience. ► Provides greater support and confidence in the negotiation base for insurers, helping to support HITH and other innovative care models.
Equity between consumers of PHI	Neutral	► No significant impact expected.
Integration and adaptability of healthcare system	Neutral	► No hospital providers have raised the issue around specialist out-of-pocket costs in contracting. No significant impact expected.
Practicality	Marginal/ Second-order Improvements	► Cost efficient and specific way to address known anti-competitive and transparency issues (see Section 3.7.1). ► Involves market self-regulation to an extent.
Affordability of PHI products	Neutral	► No significant impact expected.

Considerations and risks

The risk of introducing additional complexity should be considered, especially in light of the operational inefficiencies identified in Section 3.7.1 that led to the suggestion of an independently set funding model (Opportunity 2.A) and the standardised operational requirements for hospitals (Opportunity 1.C). As described below, implementation of this Opportunity should be deferred until it is clearer how these other Opportunities are progressing.

Impacts on stakeholders

This Opportunity would impact insurers and hospitals, and there would be a need for strong stakeholder engagement from these groups. Representatives from these sectors would form the working group that steers the development of the guidelines helping inform both the identification of issues and their appropriate response.

Hospital and insurer stakeholders would also be impacted through the new response measures available to the Department. This should positively improve their operation as it offers a more measured response to possible oversights or smaller issues that may have occurred.

Government stakeholders would be impacted, as the key administrative processes and enforcement of the guidelines would be their responsibility. The additional responsibilities and regulatory response opportunities would need to be well-understood by the relevant government stakeholders for effective and proper use post implementation.

Impact on consumers

One of the key purposes of the guidelines will be to drive broader insurer-funding of innovative services such as HITH where appropriate by describing a framework for contract negotiations. This will improve consumer access and equity to services such as HITH. The development of guidelines supported by appropriate Commonwealth legislation will allow faster responses to be issued from the regulator. This will minimise the number of consumers impacted by a particular problematic behaviour.

This Opportunity also promotes fair and competitive contracting behaviour which would decrease the administrative resources providers need to allocate to meeting conditions within contracts.

Streamlining these elements would improve the resources to be contributed towards patient care, positively impacting consumers.

4.2.3.3 Implementation and interactions

This Opportunity would require some transition for hospitals and insurers, although the Government would need to develop and understand any additional processes and rules associated with the Opportunity. This would require an investigation to understand where the gaps are in the current legislation and standards that already exist.

As noted above, introducing standardised operational expectations for all hospitals (Opportunity 1.C) should reduce inefficiencies and inconsistencies in contract terms and support a more efficient healthcare sector. Additionally, moving towards the independently set funding model (Opportunity 2.A) would reduce the opportunity for potentially anti-competitive contracting behaviour through manipulating the second-tier default benefit rates, and allow insurer-funding of innovative services such as HITH where appropriate by describing a framework for contract negotiations.

4.3 Scope of default benefit arrangements

4.3.1 Opportunity 3.A: Limit scope of second-tier default benefits eligibility to certain private hospital types and/or for certain timeframes

Opportunity 3.A objectives

The objective of this Opportunity is to limit the scope of, and/or impose timeframes for new hospitals to receive, second-tier default benefits. This would reduce the potential for any undue influence on the market.

4.3.1.1 Description

This Opportunity would allow certain specific types of private hospitals to be eligible for, and/or impose time limitations on new hospitals to receive, second-tier default benefits once they meet the default benefits application requirements (see Opportunity 1.C). This Opportunity essentially reduces the scope of second-tier default benefits. Private hospitals not in scope could apply in specific circumstances on a case-by-case basis but would have to make a stronger case and prove the value for consumers.

Analysis has indicated new private hospitals proportionally utilise second-tier default benefits more often (Figure 24). Stakeholders have been most aligned in retaining access to second-tier default benefits for independent rural and regional private hospitals, although our analysis demonstrates that these hospitals have lower utilisation of second-tier default benefits compared to new and day hospitals (Figure 13).

4.3.1.2 Assessment

Changing the scope of, and/or imposing time limitations on second-tier default benefits would focus the applicability of second-tier default benefits to the providers and services with the greatest consumer need and benefit.

The key reason to consider pursuing this Opportunity would be if it can be shown that second-tier default benefits have an undue influence on the market in the cases where they are not needed. This is as yet unproven. In particular:

- Some stakeholders have claimed that the ability to access second-tier default benefits drives an oversupply of private hospitals in certain areas creating market inefficiencies, and/or

- Some stakeholders have claimed that the presence of second-tier default benefits unduly influences the contracting process increasing the overall cost for care.

Our assessment of this Opportunity based on our current understanding is given below.

Legend			
Potential improvements	Marginal/second-order improvements	Neutral	Potential downside impacts

Table 23: Opportunity 3.A rating against assessment criteria

Assessment criteria	Assessment	Detail
Access to and choice of services	Neutral	► Our initial analysis suggests that oversupply in metropolitan areas is not a growing problem, but this issue should be monitored (see Section 3.4.1). ► Potential risk that removing, and/or imposing time limitations on second-tier default benefits may make some providers unviable and therefore limit access/choice for potential patients of those providers. Given the distribution of providers, this risk would be mitigated to a large extent if rural/regional providers remain in scope. ► A study of several countries found that selective contracting (which would be promoted through this Opportunity by limiting private hospital access to second-tier default benefits) reduced consumer trust and satisfaction in both insurer and provider.[58]
Quality and appropriateness of services	Neutral	► On its own, this Opportunity would not impact the range of operational standards of hospitals that enter the market if new hospitals (that have relatively high utilisation of second-tier default benefits) remain in scope. ► However, it should have a neutral impact if Opportunity 1.C is implemented and there is general confidence in the standard operating expectations of second-tier eligible hospitals.
Innovation and market dynamics	Neutral	► The intention of this Opportunity is to limit second-tier default benefits to private hospitals based on a set of criteria, and in doing so, increase the ability for insurers to use contracting to incentivise providers offering better value care. ► It has been suggested that removing the ability for some private hospitals to "fall back" on second-tier default benefits would reduce their influence on the contracting process. ► Whether there is potential upside to market dynamics, and the size of that upside is uncertain. Further analysis could be performed through the data collection in the process of pursuing Opportunity 2.A.
Equity between consumers of PHI	Neutral	► No significant impact expected
Integration and adaptability within the healthcare system	Neutral	► No significant impact expected
Practicality	Neutral	► No significant impact expected

Supporting analysis

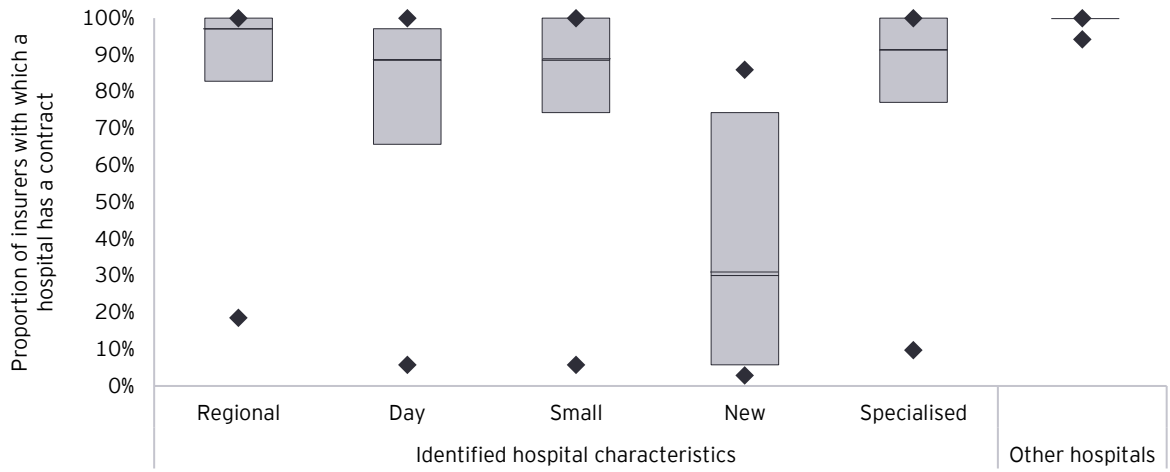
The analysis in Section 3.4.1 considered whether second-tier default benefits could be a driver of an oversupply of services in metropolitan areas. Although second-tier default benefits support the entry of new hospitals, stakeholder perspectives that funding through default benefit arrangements is leading to an oversupply of services in certain areas are difficult to definitively prove, given demographic shifts and increasing consumer expectations of healthcare. Our initial analysis in Section 3.4.1 suggested that oversupply in metropolitan areas is not a growing problem, but this issue should be monitored.

[58] Motaze, N. et. al., 2015, Government regulation of private health insurance, The Cochrane Database of Systematic Reviews, 2015 Apr 17

In this Section, we have analysed how rates of contracting between private hospitals and insurers vary by different hospital characteristics or segments. Hospitals with lower rates of contracting with insurers would be paid more through second-tier default benefits. Figure 35 shows the proportion of total insurers with which a private hospital has a contract, for each of the identified hospital characteristics, compared to other private hospitals, in an adapted box-and-whisker chart (showing the 10th, 25th, 50th, 75th and 90th percentile). Other hospitals refer to any that are not regional, day, small, new or specialised.

New hospitals in particular, as well as day, small and specialised hospitals, have lower rates of contracting with insurers than other hospitals that are paid more often through second-tier default benefits.

Figure 35: Proportion of insurers with which a hospital has a contract for identified hospital characteristics



Data source: *Data.gov.au Agreement Hospitals matrix 1 August 2022, Hospital data held by the Department, Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The boxplot presents the distribution of the proportion of insurers that a hospital is contracted with as at 1 August 2022 for different hospital characteristics. For a given hospital, this is calculated by the following:*

$$Proportion\ of\ insurers\ that\ a\ hospital\ is\ contracted\ with = \frac{Number\ of\ insurers\ indicated\ as\ having\ a\ contract}{Total\ number\ of\ insurers\ in\ Agreement\ Hospitals\ matrix}$$

- *The box represents the range between the 1st quartile and 3rd quartile of percentages, i.e., 50% of hospitals lie in this box. The diamonds represent the 10th and 90th percentile of percentages in the respective hospital characteristic.*
- *The hospital characteristics in this chart as defined as:*
  - *Regional – hospitals outside of major cities*
  - *Day – as defined in the data.gov.au matrix*
  - *Small – hospitals with less than or equal to 50 beds*
  - *New – hospitals with an opening date in 2016 or later*
  - *Specialised – hospitals with a majority of separations under a single SRG in FY21*
  - *Other – all other hospitals that do not fall under any of the above 5 characteristics*
- *Outputs are sensitive to the underlying data and our definitions of the hospital characteristics. For each characteristic, hospitals that are missing the relevant data were excluded from the analysis. Data quality issues may impact the distributions shown.*
- *Some hospital characteristic groups with low volumes may lead to a higher range. In particular, new hospitals only relate to 80 hospitals.*

Another rationale for changing the scope of second-tier default benefits to certain private hospitals and service type (which is further explored in Section 4.3) is to address arguments from insurers that private hospitals use second-tier default benefits as a floor price in contract negotiations. Removing access to second-tier default benefits for private hospitals that do not require them would remove this negotiation mechanism.

In Table 3 it is clear that a large proportion of most private hospital categories are second-tier eligible. However, as seen in Figure 15, a low proportion of separations in each hospital category are actually funded by second-tier default benefits. This may point to private hospitals applying for second-tier eligibility to support contract negotiations, potentially supporting the view that second-tier default benefits create a floor price, but may also indicate wanting to retain eligibility in case any contract negotiations fall through.

United States case study

Removing some types of private hospitals from the scope of second-tier default benefits would result in out-of-scope hospitals only being paid by insurers through contracted arrangements, if at all. Contracting between hospitals and insurers is the primary method of price setting used by the private health system in the United States.

However, in the United States insurers with large market power and a large share of the consumer population are able to influence consumers to use only "in-network" providers that they contract with. Consumer influence occurs as insurer contracts provide discounts to the cost of "in-network providers" services while out-of-network providers have no associated benefits, potentially leading to higher costs for the consumer. A similar trend has been observed in some aspects of the Australian healthcare market (for example, with allied-health services such as no-gap dental treatments with insurer-approved providers).

A consequence observed in the United States is that private hospitals are led to accept lower contract rates to remain accessible to consumers who hold a policy with large market share insurers, which may ultimately lead to the hospital's non-viability, thereby impacting consumer access and choice.

On the other hand, in the United States hospital insurance products similarly restrict coverage only to in-network providers and there is evidence that this has resulted in lower premiums and healthcare expenditures.[59] An element of this is due to reduced service utilisation, although it is unclear if consumer healthcare needs continued to be met.

Conclusion

On the one hand, the current second-tier default benefit arrangements were introduced some time ago when there were potential issues with the private healthcare market and potential risks to consumer access. If there were no default benefits and they were to be introduced today, it is unlikely that they would take the present form.

On the other hand, the private healthcare market today has new and emerging risks related to economic conditions and the COVID-19 pandemic, and there is no clear significant failure or inefficiency that is directly attributable to default benefit arrangements.

As such, it would be reasonable to take more time to understand the potential implications of reducing their scope, and/or imposing time limitations on their use. Given the overall neutral rating above, this Opportunity is not suggested to be pursued until further evidence is collected, potentially as part of exploring Opportunity 2.A in more detail.

Considerations and risks

A key consideration for this Opportunity is the associated definitional issues that could occur in describing the private hospitals who should be in scope for, and/or impose time limitations on second-tier default benefits. In assessing whether to proceed with this Opportunity, the downside risk of denying consumers access to new and innovative providers needs to be balanced against the potential upside of improving contracting efficiency.

[59] van den Broek-Altenburg EM, Atherly AJ. The relation between selective contracting and healthcare expenditures in private health insurance plans in the United States. Health Policy. 2020 Feb,124(2):174-182

Impacts on stakeholders

Stakeholders have provided strong and often directly opposing opinions towards changing the scope of and/or imposing time limitations on second-tier default benefits by private hospital type. Private hospitals that would no longer be in scope, or outside of the time eligibility, would be most impacted and be further pressured to contract, potentially at lower prices, affecting the viability of these facilities. Consumers that use these private hospitals may have to entirely self-fund. There would also be impacts on private hospitals that remain in scope due to shifting demand across the system. These secondary impacts would be complex and varied and should be understood through consultation and analysis before this Opportunity proceeds.

The table below summarises the high-level impacts of refining the scope of second-tier default benefits.

Table 24: Summary of Opportunity 3.A impacts

Positive impacts of this Opportunity	Negative impacts of this Opportunity
► Allowing regional and rural hospitals to retain access to second-tier default benefits supports consumer access in areas with fewer private hospitals. ► New private hospitals noted that it can take some years to obtain contracts from private health insurers. Allowing new private hospitals to be in-scope for second-tier default benefits, without imposing time limitations, would improve their viability thereby supporting consumer access and choice. ► Limiting the scope of, and/or imposing time limitations on second-tier default benefits to areas with high unmet need, and excluding those with sufficient supply of private hospitals, would limit the growth of benefits paid by health insurers and encourage contracting.	► Some private hospitals have claimed that their ongoing viability in providing important services to consumers is dependent on them receiving second-tier default benefits. Refining the scope of, and/or imposing time limitations on second-tier default benefits could threaten the viability of some private hospitals leading to higher hospital out-of-pocket costs or possible closures, which reduces consumer access and choice. ► If new private hospitals are not eligible for second-tier default benefits, there may be a shift towards existing private hospitals which also reduces consumer access and choice.

Impact on consumers

By limiting the scope of, and/or imposing time limitations on second-tier default benefits, which some private hospitals are reliant on, this Opportunity may reduce consumer access and choice to private hospitals.

4.3.1.3 Implementation and interactions

An independently set funding model (Opportunity 2.A) requires a strong degree of collaboration across the private healthcare sector. Reducing the scope of, and/or imposing time limitations on second-tier default benefits under this Opportunity would have the potential to undermine sector support for pursuing Opportunity 2.A as well as its ultimate effectiveness in supporting contracting. At the same time, the data collected and analysed in future considerations relating to the independently set funding model could provide a useful basis for further analysis into any potential negative consequences of second-tier default benefits applying to private hospitals where it is not required. Therefore, it would be most appropriate to revisit this Opportunity following the implementation of an independently set funding model.

4.3.2 Opportunity 3.B: Refine scope of default benefit arrangements to certain service types and new models of care

Opportunity 3.B objectives

The objective of this Opportunity is to support consumers to access and choose the services they require through incentivising innovative and efficient services that optimise consumer health outcomes, and disincentivising those services that do not.

4.3.2.1 Description

This Opportunity for reform considers refining the scope of default benefit arrangements to certain health service types. This could involve excluding services that currently receive default benefits, for example in-hospital services that can be shown not to optimise consumer health outcomes, and/or expanding to service types performed outside of hospitals that are currently excluded, for example HITH services. HITH services have been a key innovative service type that all stakeholders have stated is valued by consumers. However, there are mixed views on how this should be funded and the role default benefits should play.

This Opportunity could be used in conjunction with the previous Opportunity to limit the scope of default benefit arrangements to certain private hospital types (see Section 4.3.1).

4.3.2.2 Assessment

The reason for considering this potential reform Opportunity is to improve the current default benefit arrangements, particularly the access to and choice of services, innovation and market dynamics and affordability of PHI products. However, there is insufficient evidence at this stage to prove that it would.

Our assessment of this Opportunity based on our current understanding is given below. In summary:

- There are more effective mechanisms available for incentivising in-hospital services that optimise consumer health outcomes, such as the accreditation and licensing/registration processes. These are intended to provide consumers with confidence in the safety and quality of all private hospitals, and therefore should not be required to be limited by default benefit settings, and

- There are significant risks in expanding default benefits to include HITH services at this stage. However, Opportunities 2.A and 2.C could provide a stronger path forward to expand the benefits.

Further evidence would be required before pursuing this Opportunity further.

Legend			
Potential improvements	Marginal/second-order improvements	Neutral	Potential downside impacts

Table 25: Opportunity 3.B rating against assessment criteria

Assessment criteria	Assessment	Detail
Access to and choice of services	Neutral	► Including HITH services could increase the choice and access for consumer separations funded through default benefits. ► However, there could be market implications that may impact supply, quality and affordability.
Quality and appropriateness of services	Neutral	► Potentially improved consumer outcomes could be achieved through this Opportunity – through disincentivising lower-quality in-hospital services and incentivising more appropriate HITH services. ► This may be diluted in practice because medical practitioners and the broader mechanisms that determine funding sources have the most significant impact on consumer outcomes. ► Including more service types requires additional controls to support quality and safety, which may be difficult to implement.
Innovation and market dynamics	Neutral	► Allowing only hospital-run HITH services could distort the market for HITH provision by making harder for non-hospital providers to compete.
Equity between consumers of PHI	Neutral	► No significant impact expected.

Assessment criteria	Assessment	Detail
Integration and adaptability of healthcare system	Neutral	▸ Potential for integration across the patient pathway, not just in-hospital. ▸ This may be diluted in practice because medical practitioners and the broader mechanisms that determine funding sources have the most significant impact on consumer outcomes.
Practicality	Neutral	▸ No significant impact expected.
Affordability of PHI products	Neutral	▸ This Opportunity should support a better value healthcare pathway, reducing overall funding. ▸ However, increasing the scope of default benefit arrangements could drive higher utilisation of services as well as increasing the potential scope of insurer-funded services – both of which would put further pressure on PHI premiums.

Considerations and risks

As described in the table above, there are a number of risks that should be better understood before this Opportunity is pursued further. These include:

- Risks of issues identified with the current default benefit arrangements being exacerbated.
- Risks of increased premiums if utilisation and the scope of PHI-funded services increase.
- Which types of services should be accessible for certain conditions.
- Associated HITH safety and quality considerations, which should be determined by the ACSQHC.
- Definitions of HITH services and their scope in relation to an admitted private hospital episode.
- The roles and responsibilities of hospitals, service providers, medical specialists, insurers and regulators.
- Risks of distorting the HITH provider market if there are differences in treatment between hospital-run and non-hospital HITH providers.
- Ineffectiveness at driving consumer outcomes given the broader funding mechanisms that exist around private healthcare services and the influence of medical specialists on the pathways chosen.

Impacts on stakeholders

Private hospital stakeholders were generally in favour of expanding default benefit arrangements to hospital-run HITH services to allow them to deliver more innovative services. There is little support from this stakeholder group to limit default benefit arrangements for certain health services as they consider that determining appropriate patient care is primarily the responsibility of the medical specialist.

Health insurers believe expanding default benefit arrangements to innovative services such as HITH is not required as these innovative services can be funded through contracts. They point to the risks described above.

Impact on consumers

At this stage it is unclear whether this Opportunity would increase choice and access to services that optimise consumer health outcomes.

4.3.2.3 Implementation and interactions

The same implementation and interactions apply to this Opportunity as to Opportunity 3.A (Section 4.3.1). It would be most appropriate to revisit this Opportunity following the implementation of an independently set funding model (Opportunity 2.A) and the development of market guidelines for insurers, hospitals and regulators (Opportunity 2.C).

5. Next steps

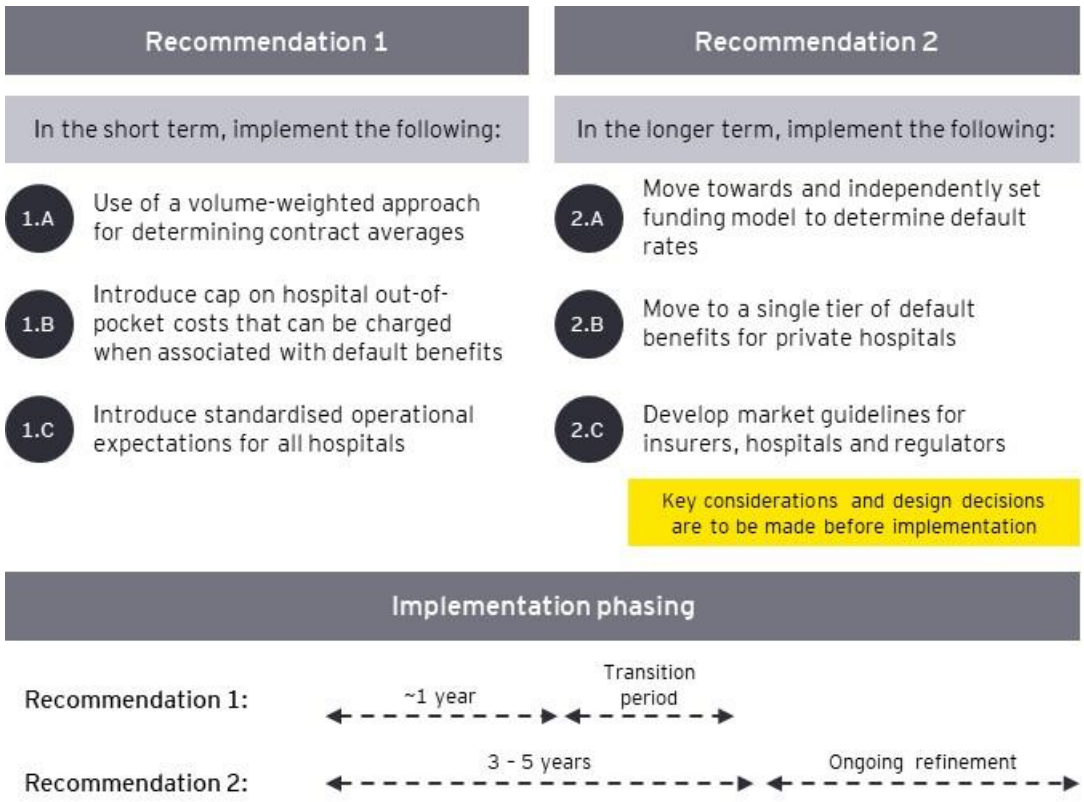
This Section provides recommendations for a way forward for reforming default benefit arrangements that brings together the different specific Opportunities already identified whilst also considering underlying process improvements and interactions with broader reforms to PHI.

5.1 Recommendations for reform of default benefit arrangements

Our recommendations have been developed with regard to prioritising outcomes that will most benefit PHI consumers. Healthcare funding in the private system involves many stakeholders operating under complex regulations and contracting arrangements, and so consideration has been given to the feasibility of transition and implementation of our recommendations and potential impacts on non-consumer stakeholders including hospitals, medical specialists, insurers and government.

We have identified *two Recommendations* for the reform of default benefit arrangements, which are described in more detail below. The next steps towards implementation of both of these could begin in parallel, as shown in Figure 36.

Figure 36: Overview of Recommendations



5.1.1 Recommendation 1: short-term reform of default benefit arrangements

This Recommendation has three Opportunities intended to directly address most of the current issues with default benefit arrangements described in Section 1.2.

- **Opportunity 1.A: Use of a volume-weighted approach for determining contract averages**

  Overall objective: to reduce the potential risk of manipulation of second-tier default benefit rates and to align them with actual contract rates paid. This should support sufficient insurer funding to providers so that they are viable without the need to charge excessive hospital out-of-pocket costs, thereby supporting consumer access and choice.

  To support improvements in transparency and consistency around the application of the new formula, consideration could be given to developing specific audit guidelines and a mechanism for enabling the Department direct visibility of underlying calculations

  See Section 4.1.1 for more detail on this specific Opportunity.

- **Opportunity 1.B: Introduce a cap on hospital out-of-pocket costs that can be charged when associated with default benefits**

  Overall objective: to protect consumers from the potential for high out-of-pocket costs that could otherwise be charged by some second-tier funded providers. Implementing 1.A above should reduce some of the pressure on second-tier funded providers to charge hospital out-of-pocket costs.

  See Section 4.2.1 for more detail on this specific Opportunity.

- **Opportunity 1.C: Introduce standardised operational expectations for all hospitals**

  Overall objective: to promote better operational practice expectations (such as mandating the use of national digital health infrastructure, such as Digital Health Records, or participation in nationally recognised clinical registers), reduce inefficient and duplicative contract terms, and to improve the timeliness, quality and consistency of data reporting. These requirements would apply across all private hospitals via the private hospital declaration process, regardless of whether they are funded through default benefits or contracts. This should support a more efficient private healthcare sector, to the ultimate benefit of consumers.

  See Section 4.2.2 for more detail on this specific Opportunity.

  Note that Opportunity 2.C (below), develop market guidelines for and in consultation with insurers, hospitals and regulators, is intended to align with and build upon this Opportunity in order to drive better-practice and support innovation.

Although these components are relatively straightforward to implement there are a number of design decisions to be made (including updating relevant Commonwealth legislation), which will require stakeholder consultation to optimise.

A summary of our assessment is shown in Figure 37 below, with further details in Table 26.

Figure 37: Summary assessment of Recommendation 1

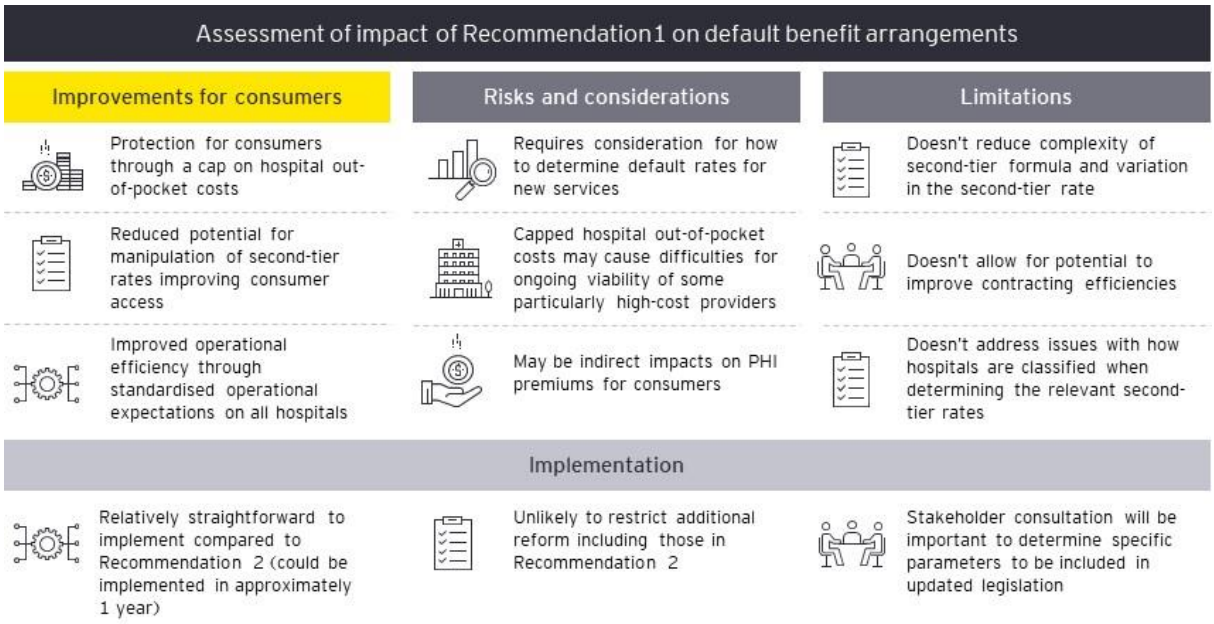


Table 26: Detailed assessment of Recommendation 1

Statement in Figure 37	Further description	Reference to opportunities in Section 4
Improvements for consumers		
Protection for consumers through a cap on hospital out-of-pocket costs	The relatively small number of consumers who receive large hospital out-of-pocket charges would immediately benefit from a cap on hospital out-of-pocket costs. As seen in Figure 23, a higher proportion of separations under second-tier default benefits pay hospital out-of-pocket costs. However, where paid, contracted separations pay higher hospital out-of-pocket costs on average. There are limitations in this analysis of HCP1 data in identifying the contract status of separations (see Section 5.2.1), which impact the robustness of these statistics.	► Section 4.2.1
Reduced manipulation of second-tier rates improving consumer access	Consumers would benefit from this Recommendation by having greater choice of and access to private hospitals who are supported by second-tier default benefit arrangements. This Recommendation should also reduce hospital out-of-pocket costs for consumers, with negligible impact on PHI premiums (see limitations below).	► Section 4.1.1
Improved operational efficiency through standardised operational expectations on all hospitals	Standardised operational practice expectations, reducing inefficient and duplicative contract terms, and improving the timeliness, quality and consistency of data reporting should support a more efficient private healthcare sector, to the ultimate benefit of consumers. Additionally, greater standardisation across operational requirements would provide more consistency to the consumer experience (such as enabling consumers to access information via nationally recognised clinical registers).	► Section 4.2.2
Risks and considerations		
Requires consideration for how to determine default rates for new services	A specific allowance could be made for new services where there is little or no volume such that this Recommendation does not inhibit the uptake of new and innovative treatments. This would require consideration under this Recommendation.	► Section 4.1.1
Capped hospital out-of-pocket costs may cause	Introducing a cap on hospital out-of-pocket costs could result in a negative downstream impact on access to and	► Section 4.2.1

Statement in Figure 37	Further description	Reference to opportunities in Section 4
difficulties for ongoing viability of some particularly high-cost providers	choice of services if the caps are unsustainable for hospitals. However, some consumers do not mind paying more to have choice to access their preferred provider.	
May be indirect impacts on PHI premiums for consumers	The use of a volume-weighted approach for determining contract averages should reduce hospital out-of-pocket costs for consumers, however it may also result in a negligible[60] increase in PHI premiums if benefits increase.	► Section 4.1.1
Limitations		
Doesn't reduce complexity of second-tier formula and variation in the second-tier rate	Using a volume-weighted approach for determining contract averages would enable the second-tier default benefit rate to be more reflective of actual contracted rates paid. Although it would address a specific issue with the current arrangements, it would not reduce the complexity of the second-tier formula or the variation in the second-tier rate. As part of Recommendation 1, we recommend Opportunity 1.A be considered as an interim approach to immediately improve confidence and consistency across the sector while a longer-term reform opportunity, such as the independently set funding model (Opportunity 2.A), is developed.	► Section 4.1.1
Doesn't allow for potential to improve contracting efficiencies	A key limitation of Recommendation 1 compared to Recommendation 2 is that it does not provide additional information or tools to allow the sector to improve contracting efficiencies, as would be enabled under Recommendation 2.	N/A
Implementation		
Relatively straightforward to implement compared to Recommendation 2 (could be implemented in approximately 1 year)	Introducing a cap on hospital out-of-pocket costs would be relatively straightforward to implement on a process level, as it could be aligned with adjusting the formula in Opportunity 1.A (see Section 4.1.1). The impact on the system should be taken into consideration and worked through via consultation with providers, which could impact timelines. Expected timeframes for using a volume-weighted approach for determining contract averages would be relatively short – perhaps one year from beginning consultation. Legislative changes would have to be made to the calculation methodology detailed in Schedule 5 of the *Private Health Insurance (Benefit Requirements) Rules 2011*. Movement to the new calculation methodology would need to align with the current timeframes for submission of the new annual second-tier schedules. Introducing standardised operational expectations for all hospitals could take a longer time to implement (but still would be more straightforward than Recommendation 2) depending on the scope of the changes. It would rely on stakeholder consultation to develop a standardised set of expectations and definitions and a transition period for hospitals to comply with new requirements. Recommendation 1 could be implemented whilst Recommendation 2 is also being pursued (specifically whilst Opportunity 2.A is being developed and implemented).	► Section 4.1.1, Section 4.2.1, and Section 4.2.2

[60] Assuming the change in the calculation methodology has no impact on the contract status between a private hospital and insurer, the impact on total second-tier funded claims cost is estimated to be approximately 10% based on the shortfall to 85% of contracted rates seen in Table 13 and Table 14. Given that approximately 1.5% of separations are funded through second-tier default benefits (Figure 10), the impact on total claims costs for insurers would be approximately 0.1% (10% x 1.5%) and therefore, negligible impacts on PHI premiums paid by consumers.

Statement in Figure 37	Further description	Reference to opportunities in Section 4
Unlikely to restrict additional reform (Recommendation 2)	Reforms under Recommendation 1 are not expected to restrict additional reform (under Recommendation 2) but are intended as initial steps to directly address some of the current issues with default benefits described in Section 3. Reforms under Recommendation 2 are intended to drive further efficiencies (in addition to those under Recommendation 1) within default benefit arrangements, as well as potentially enabling benefits for contracted arrangements. Additionally, introducing a cap on hospital out-of-pocket costs alongside using a volume-weighted approach for determining contract averages could be introduced together. On average, this would support consumers with lower hospital out-of-pocket costs when higher second-tier default benefit rates are paid to private hospitals.	► Section 4.1.1, Section 4.2.1, and Section 4.2.2
Stakeholder consultation will be important to determine specific parameters to be included in updated legislation	Stakeholder consultation will be important for the following components of the recommended reform: ► Determining an approach for treating new services where there is little or no volume, under a volume-weighted approach for determining contract averages. ► Considering the impact on the private hospital system, and the appropriate level for the cap on hospital out-of-pocket costs. ► Introducing standardised operational expectations for all private hospitals via the hospital declaration process would rely on stakeholder consultation to develop a standardised set of expectations and definitions.	► Section 4.1.1, Section 4.2.1, and Section 4.2.2

5.1.2 Recommendation 2: longer-term reform of default benefit arrangements

This Recommendation has three opportunities intended to drive further efficiencies (on top of those delivered through Recommendation 1) within default benefit arrangements, as well as potentially enabling benefits for contracted arrangements.

► **Opportunity 2.A: Introduce an independently set funding model**

This Opportunity involves an alternative approach to determining the default benefit rates. Second-tier default rates (and optionally minimum default benefits) would be determined by an independent body using a funding model to determine a benchmark price alongside weighted activity units for services. This could be similar to the National Efficient Price (NEP) model which underpins activity-based funding for public hospital services.

Overall objective:

To provide consumers with confidence that the safeguard level of default benefits supports adequate funding for safe and quality care. It would achieve this by improving the consistency and robustness of second-tier default benefit rates, reducing inefficiencies associated with wide price variation for similar services, and further reducing the administrative burden associated with default benefit rates.

With sufficient confidence that the default rates provide adequate funding to support the provision of safe and quality care, there should be less need for private hospitals to charge hospital out-of-pocket costs, and so the cap from Opportunity 1.B could be further revised.

In combination with Opportunity 2.C below, the independently set funding model could be designed to provide a framework for broader insurer funding of care types such as HITH where appropriate.

The increased transparency of cost data and benchmark pricing for the purpose of determining second-tier default benefit rates could also enable broader efficiency benefits for contracted arrangements. The expectation is for these efficiencies in contracting to flow onto consumers in the form of increased value from their PHI products.

See Section 4.1.2 for more detail on this specific Opportunity.

- **Opportunity 2.B: Move to a single tier of default benefits for private hospitals**

  Overall objective: The intended purpose of minimum benefits is to provide choice to PHI consumers by funding private patients in public hospitals and to protect consumers by providing a level of benefit for private hospital services where their product only offers restricted benefits. This Opportunity intends to retain the same approach for setting minimum benefit rates in alignment with these two intended purposes in the short term. This would eventually shift to applying the independently set funding model for private hospitals when available (Opportunity 2.A), thereby reducing the complexity of the minimum benefits for private hospitals but retaining their purpose for public hospitals.

  See Section 4.1.3 for more detail on this specific Opportunity.

- **Opportunity 2.C: Develop market guidelines for insurers, hospitals and regulators**

  Overall objective: To further support contracting efficiency (achieved through Opportunity 1.C) by promoting common terminology, definitions and performance measures (for example PROMs and PREMs), drive operational better-practice beyond standard expectations as described in Opportunity 1.C, drive broader insurer-funding of innovative services such as HITH where appropriate by describing a framework for contract negotiations, promote fair and competitive contracting behaviour on both insurer and hospital sides, and to enable a proportional set of responses for the regulator through appropriate Commonwealth legislation. This would enable faster action to be taken that would overall reduce the number of consumers impacted by potential anti-competitive behaviour.

  See Section 4.2.3 for more detail on this specific Opportunity.

There are several considerations to work through with stakeholders, including detailed information collection and analysis and a transition period.

A summary of our assessment is shown in Figure 38 below, with further details in Table 27.

Figure 38: Summary assessment of Recommendation 2

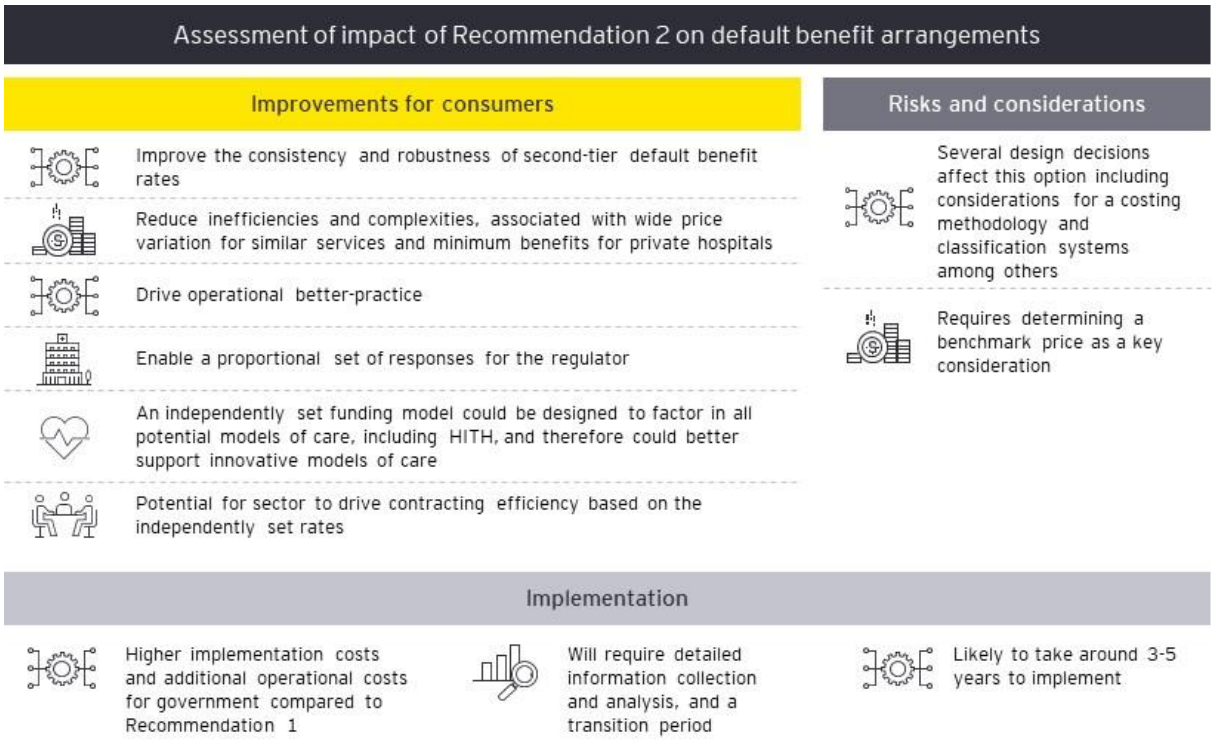


Table 27: Detailed assessment of Recommendation 2

Statement in Figure 38	Further description	Reference to opportunities in Section 4
Improvements for consumers		
Improve the consistency and robustness of second-tier default benefit rates	A transparent, evidence-based rate would be immune to changes in contracting practice that should not impact second-tier default benefits. This should assist in default benefit arrangements continuing to support viable service provision and ultimately, the consumers' access and choice of services. Consumers would experience more choice between and access to service providers (medical specialists and private hospitals) with the second-tier default rates more closely reflecting actual payments required to ensure private hospital viability.	► Section 4.1.2
Reduce inefficiencies and complexities, associated with wide price variation for similar services and minimum benefits for private hospitals	Reduced price variation in the second-tier default benefit rates reduces the inefficiencies associated with monitoring and billing and contributes to more consistency in the second-tier default benefit rates. The reduced inefficiencies and more certainty from private hospitals on the operationalisation of their service offering benefits consumers through cost savings and supporting choice and access of services. Recommendation 2 would also result in further administrative savings and therefore, savings for the consumer, as the structure of minimum benefits aligns with the existing NEP (for public hospitals) and second-tier default benefits (for private hospitals processing restricted benefits), while removing the complexity of an additional tier of default benefits for private hospitals.	► Section 4.1.2
Drive operational better-practice	One of the key purposes of the market guidelines will be to drive broader insurer-funding of innovative services such as HITH where appropriate by describing a framework for contract negotiations, promote fair and competitive contracting behaviour on both insurer and hospital sides. This will minimise the number of consumers impacted by potential anti-competitive behaviour.	► Section 4.2.3

Statement in Figure 38	Further description	Reference to opportunities in Section 4
Enable a proportional set of responses for the regulator	The development of market guidelines with a proportional set of responses for the regulator will allow for faster responses to non-compliance or any identified issues, minimising the number of consumers impacted by any problematic behaviour.	► Section 4.2.3
An independently set funding model could be designed to factor in all potential models of care, including HITH, and therefore could better support innovative models of care	The funding model could be designed to factor in other models of care, including HITH. This would better support innovative models of care being delivered in the private health industry and improve consumers' access to these services.	► Section 4.1.2
Potential for sector to drive contracting efficiency based on the independently set rates	Contracting efficiency would be improved by creating a starting point for negotiations based on more transparent information. Consumers would benefit through the efficiency and administrative cost reductions ultimately leading to lower PHI premiums and lower hospital out-of-pocket costs. Additionally, greater standardisation across contracts would decrease the administrative resources required by providers to meet conditions within contracts. Streamlining these elements would improve the resources to be contributed towards patient care, positively impacting consumers.	► Section 4.1.2 and Section 4.2.3
Risks and considerations		
Several design decisions affect Recommendation 2 including considerations for a costing methodology and classification system among others	This Recommendation is complex in nature, with a number of considerations that will need to be worked through prior to implementation. These include, but are not limited to: ► How necessary data is collected from the sector and associated governance arrangements. ► The classification system(s) used in the design of the model. ► The costing methodology used. ► What costs are included and funded in the model, and consideration of other funding sources in the private sector. ► Adjustments to account for different characteristics. ► The frequency in which the funding model is updated.	► Section 4.1.2
Requires determining a benchmark price as a key consideration	A decision will need to be made around how the benchmark price is determined, for example through a cost-plus approach, using existing contracted rates, or a blended approach between the two. If a cost-plus approach is used, margin assumptions would need to be developed and agreed.	► Section 4.1.2
Implementation		
Higher implementation costs and additional operational costs for Government compared to Recommendation 1	We anticipate that the key activities in developing an independently set funding model include consultation with industry, collection of data and data analysis. The development of the Recommendation should consider the possible flow-on effects on contracting and demand in the public system. In addition to the development of the funding model, this Recommendation should be established, with consideration of the new administrative and legal implications, legislative changes, resourcing and funding for the independent body, and annual processes associated with an independently set funding model. These requirements will incur higher implementation costs and higher operational costs compared to Recommendation 1.	► Section 4.1.2, Section 4.1.3 and Section 4.2.3

Statement in Figure 38	Further description	Reference to opportunities in Section 4
	Changes to minimum benefits would be made following the adoption of the independently set funding model. However, consultation and an understanding of the potential impacts, in particular on public hospital funding, would need to occur prior to implementation. The development of market guidelines would impact insurers and hospitals, and there would be a need for strong stakeholder engagement from these groups. Representatives from these sectors would form the working group that steers the development of the guidelines helping inform both the identification of issues and their appropriate response.	
Will require detailed information collection and analysis, and a transition period	An independently set funding model would require consultation with industry, collection of data and data analysis. Due to the complexity of this Opportunity within Recommendation 2, it is important that sufficient time and support is provided to assist private hospitals and private health insurers with the transition process. This may involve a possible shadow period whereby the current arrangements would continue and the new independently set funding model would be fully operational and available to stakeholders (but without being applied to determine the new second-tier default benefits in practice).	▸ Section 4.1.2
Likely to take around 3-5 years to implement	From the consultation and scoping stage, the rough timeline for this Recommendation could be 3 to 5 years.	▸ Section 4.1.2, Section 4.1.3 and Section 4.2.3

Making use of available data, as well as making improvements to the collection processes and the potential of the data will be critical, and should be driven in part through the detailed considerations relating to the independently set funding model (Opportunity 2.A). See Section 5.2.1 for further discussion on specific data improvements that would be useful.

Section 5.4 discusses broader reforms that have a potential implication on how default benefit arrangements should operate. The direction of these broader reforms should be considered under all of the specific opportunities. In particular, opportunities that would change the scope of default benefit arrangements (Opportunity 3.A and Opportunity 3.B) should be considered in light of the development of these broader reforms, emerging findings based on enhanced data analysis and learnings from implementing Opportunities 1.A to 2.C.

5.1.3 Additional opportunities for default benefit arrangements reform not recommended at this time

Possibilities for changing the scope of default benefit arrangements that have been considered but are not recommended at this time are as follows:

- **Opportunity 3.A: Limit scope of second-tier default benefits eligibility to certain private hospital types and/or for certain timeframes.** By limiting the scope of and imposing time limitations on second-tier default benefits, which some private hospitals are reliant on, this Opportunity may reduce consumer access to and choice of private hospitals. Therefore, at this stage limiting access to default benefit arrangements to certain hospital types or via time limitations is not recommended.

  See Section 4.3.1 for more detail on this specific Opportunity.

- **Opportunity 3.B: Refine scope of default benefit arrangements to certain service types and new models of care** – with two possible directions:

- Excluding certain "low value" service types in hospitals – This is not recommended at present as the accreditation and licensing/registration processes are intended to provide consumers with confidence in the safety and quality of all hospital services and private hospitals, and therefore should not be required to be limited by default benefit settings. Furthermore, where default benefit arrangements could better support the efficiency and value of services delivered, this could be more effectively delivered through Recommendations 1 and 2. That there is some evidence that "low value" services have been funded through default benefits suggests a need for improved co-ordination between the different levels of government regulators.

- Including additional innovative service types such as HITH – While we have identified issues related to the provision and funding of HITH services, as discussed in Section 4.3.2, these can be better addressed through an independently set funding model and market guidelines for insurers, hospitals and regulators (as noted in the benefits described under Opportunities 2.A and 2.C).

- Whilst current arrangements allow for HITH funding through contracting, there are broader considerations to support the availability of these services outside of default benefits funding. In particular, a structured approach is required that considers the types of services that should be accessible for certain conditions, associated safety and quality considerations by the ACSQHC, definitions of services and their scope in relation to an admitted private hospital episode, roles and responsibilities of hospitals, service providers, medical specialists, insurers and regulators, and associated costs.

  This structured approach should be considered in developing the independently set funding model (Opportunity 2.A) and in developing appropriate terms and conditions via market guidelines (Opportunity 2.C).

Therefore, after consideration expanding the scope of default benefit arrangements to include additional innovative service types such as HITH is not recommended in the current settings. See Section 4.3.2 for more detail on this specific Opportunity.

While Opportunities 3.A and 3.B are not currently recommended for the reasons described above, their potential impact could be revisited following the implementation of an independently set funding model described under Recommendation 2.

5.2 Supporting process improvements

5.2.1 Data improvements

The submission of HCP and PHDB data is prescribed in legislation, offering immediate transparency of services provided and is a rich source of direct patient safety and quality performance information. Data provides insight into underlying existing diseases, surgical and non-surgical interventions, clinician, outcomes and patient demographics such as age and length of stay.

The HCP and PHDB datasets provide the Department with a valuable source of detailed information, crucial to its role in ensuring its policies support a sustainable private healthcare sector. The legislation mandates hospitals and insurers to contribute towards these datasets. However, through this study, a number of opportunities for improving the HCP and PHDB datasets have been identified. These are summarised below, with further detail given in Appendix D:

- Improvements in capturing the contracting status applicable to the separation via either a new variable introduced within the HCP and PHDB, or the existing hospital contract status variable redefined to capture the funding arrangement that applies to each separation. As noted in Section 2.3.2, the absence of such a variable was a key limitation to the interpretation of analysis outputs from this study.

- New facilities and campuses are identified by a unique provider ID.

- Consistency in classification versions used, whereby hospitals are required to report updated version of AR-DRG codes and Australian national sub-acute and non-acute patient (AN-SNAP) classifications.

- Clearer definition is supplied for the various charge and benefit buckets reported in HCP1.

- Clarity on the scope of HCP2, and improvements in data collection, quality and completeness of this dataset.

- Improvements in data quality and completeness of data for private patients in public hospitals within the HCP1.

5.2.2 Cross-industry collaboration

Throughout this study, differing stakeholder viewpoints create difficulty in understanding a clear way forward. It is clear there is considerable value in continuing and enhancing cross-industry forums and consultations to continue discussing ways forward and reform opportunities with a balanced perspective.

There are several key reasons continued cross-sector collaboration is valuable:

- The sector is a private market, creating opportunity for the market to operate through transparency and develop innovative and mutually agreed solutions that have the consumers' needs at the forefront of its design. Regulation is only needed to support consumers' needs where shortfalls are identified.

- All of the proposed potential reform Opportunities in this study would require consultation to evaluate stakeholder interest and system implications. Given the likelihood of divergent views, cross-sector collaboration is an opportunity to find a middle ground and mutually beneficial ways forward.

- Some of the potential reform Opportunities require direct support from stakeholders, requiring them to play an integral role in the ongoing support of the Opportunity. For example, the increased provision of appropriate data is fundamental in supporting the independently set funding model (Opportunity 2.A), and market guidelines (Opportunity 2.C) would be most effective if developed by industry. It is therefore essential stakeholders, including PHI consumers, play a role co-designing these ongoing processes and understanding how their respective organisations are impacted.

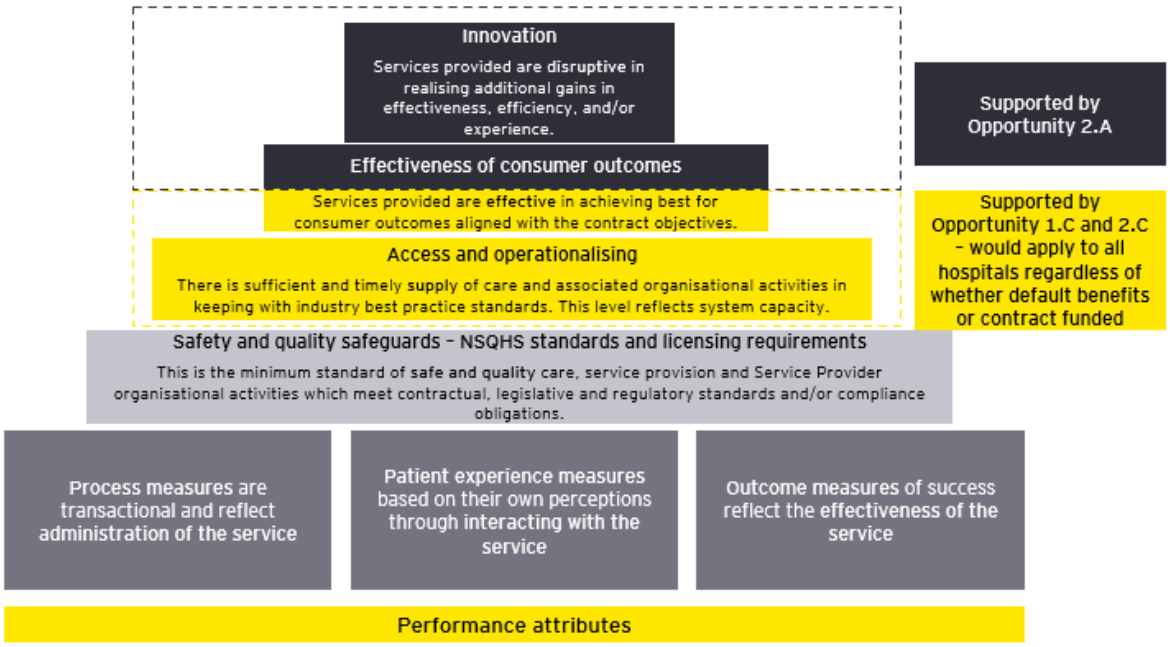
- Default benefit arrangements are one of many specific policy levers. Many of the issues identified throughout this study have far more wide-reaching impacts beyond the scope of default benefit arrangements. For example, how best to fund innovative services such as HITH is a broader question that exists above the scope of default benefit arrangements. Developing solutions around these issues requires the sharing of information and working groups across both private hospitals and insurers, collaboratively developing solutions in consultation with PHI consumers where default benefits may be able to a play a role.

5.3 Future state of contracting

This Section describes how private health insurer/private hospital contracting might operate if all of the Opportunities discussed above were implemented. It is intended to assist with understanding potential implications on stakeholders.

EY has developed a "performance pyramid" describing how different aspects of performance can be achieved when attached to funding mechanisms. Its applicability to future PHI contracting, in particular following the implementation of the independently set funding model (Opportunity 2.A), the standardised operational requirements for hospitals (Opportunity 1.C) and market guidelines (Opportunity 2.C), is shown in Figure 39.

Figure 39: EY's performance pyramid with applicability to PHI contracting



If all Opportunities were implemented, a private health insurer and a private hospital would not need to negotiate on the following:

- ***Safety and quality safeguards*** that support the provision of safe care (that would therefore not need to be included in the contract).
- Their respective market behaviours (Opportunity 2.C) through the contract period.
- Known KPIs that support ***access and operationalising*** and some more standard cross-sector expectations of outcomes under ***effectiveness of consumer outcomes*** (which would only need to be referred to in the contract).

Contract negotiations would be focussed on supporting the ***effectiveness of consumer outcomes*** and ***innovation*** through:

- Pre-agreed measures and definitions for potential bespoke KPIs that relate to ***effectiveness of consumer outcomes*** and ***innovation***.
- A pre-defined contract structure.
- Access to the latest published benchmark price schedules with supporting information on hospital sector costs and agreed contract rates.

The negotiations would then have a framework of key pre-identified decisions focussed on supporting the ***effectiveness of consumer outcomes*** and ***innovation***, selecting targets and thresholds that align with the pre-agreed measures and definitions and corresponding loadings to the benchmark price schedules. It would remain possible to also include other KPIs that might exist outside of hospital services.

If a contract cannot be agreed upon, then the default price would apply (potentially comprising a split between hospital out-of-pocket costs and the insurer contribution). Both parties would have confidence that ***compliance*** and ***access and operationalising*** expectations would be met.

5.4 Broader reforms

Most of the issues identified in Section 3 have a range of root causes, which changes to default benefits alone could not be expected to address. Indeed, the opportunities identified in Section 4 would only have limited success in supporting a viable and sustainable private healthcare sector in isolation.

A selection of related areas of reform that should be considered is given below. In each case, once a direction for reform has been decided, consideration should then be given as to how default benefits would be impacted and therefore how the arrangements will require adapting.

5.4.1 Private hospital licensing/registration and accreditation

Accreditation and licensing/registration processes are intended to provide consumers confidence in the safety and quality of all private hospitals that might receive funding from private health insurers. In doing so, the process needs to be administratively efficient and consistent in application across all hospitals in all States and Territories.

Currently the States and Territories have different hospital licensing/registration requirements, with stakeholders reporting this creates the potential for some private hospitals to receive default benefits or contracted benefits where they would not in other jurisdictions. In addition, interim accreditation is awarded to new hospitals, with a 12-month provision for full accreditation, this may lead to variations in safety and quality in this time, potentially increasing the risk of harm to consumers. It should also be noted the overall sufficiency of the existing standards could be reviewed, although outside of the scope of this study.

We note that there is a project underway by the ACSQHC focussed on the current licensing/registration and national safety and quality accreditation arrangements for certain types of services.[61]

5.4.2 Risk equalisation

Changes to RE are intended to improve incentives for the PHI industry to deliver claims efficiency savings.

The enablement of more efficient contracting based on more transparent data through the independently set funding model (Opportunity 2.A) is one way that insurers (and private hospitals) might be able to realise claims efficiency savings. As such, these reforms should align in creating a more consistent operating environment for savings to be identified and delivered to consumers.

Furthermore, it appears that there may be synergies in the direction of the reforms in RE and default benefit arrangements should a single independent agency be responsible for both setting prospective RE parameters and determining benchmark prices. Some of the data, analysis and processes could presumably be aligned, and the timeframes for reform could be similar and worked through in parallel.

5.4.3 Prostheses List reform

Reforms relating to the PL are underway and are intended to align prostheses prices with the public system and to reduce the cost of medical devices used in the private health sector and streamline access to new medical devices.[62]

[61] Information on this project is available at Cosmetic Surgery Project (www.safetyandquality.gov.au/standards/cosmetic-surgery-project).

[62] Department of Health and Aged Care. 2023. The Prostheses List Reforms. Available at: www.health.gov.au/topics/private-health-insurance/the-prostheses-list/the-prostheses-list-reforms

One of these reforms involves IHACPA providing advice to the Department on alternative bundling arrangements for General Use Items that are in the process of being removed from the PL. For these items, alternative bundling arrangements would mean that the items taken off the PL would now be bundled together with accommodation and theatre benefits.

There may be moves in the future towards bundling prostheses items, whether through advice or mandatory. In this situation changes in default benefit arrangements towards an independently set funding model (Opportunity 2.A) could align if broad cost and contract data by DRG are being collected and published.

5.4.4 PHI product design and classification

New product classifications (Gold, Silver, Bronze and Basic "product tiers") were introduced from 1 April 2019 with the intention of improving comparability for consumers as well as providing consumers with confidence in the level of cover offered by a product. However, the effectiveness of this recent policy change should be continually monitored, with specific considerations including:

- **Updating/redefining product tiers:**
  - With "plus" subcategories as well as the overall tiers, it is unclear whether the intention to ease consumer comparability has been achieved.
  - The actual distribution of products in the marketplace within tiers may be becoming skewed. This might mean reconsidering consumers' clinical needs and the insurability of combinations of product components.
  - Changes to RE (see Section 5.4.2) may be more effective with the inclusion of product tiers as a risk factor and/or boundary between RE pools.

  Any changes to product would have a flow-on impact on the insurer/hospital contracting environment as well as the distribution of private separations.
- **Restricted benefits:** Through this study we have heard some stakeholder views around the appropriateness of restricted benefits and whether they meet consumer needs and contribute towards the value proposition of PHI. As minimum benefits are currently used to set insurer funding towards these benefits, any changes would have implications on these.
- **Limited provider coverage:** We have also heard views from some stakeholders on the possibility of allowing products to only cover treatment at certain hospitals. Any change in that direction would have implications on the need for default benefits at other hospitals.

5.4.5 Private patients in public hospitals

There is ongoing discussion around the appropriateness of private funding for patients in public hospitals, and how this should be supported through PHI product design and the classification rules discussed above.

As minimum benefits is the current mechanism for private health insurer payments to public hospitals, any change in this policy would have implications on the default benefits arrangements.

5.4.6 New models of care and hospitals in the home

Hospitals in the home and other innovative models of care are important for supporting the sustainability and efficiency of the healthcare system more broadly as well as meeting consumer needs and expectations. As with all aspects of the Australian healthcare system, a balance between Government funding, private health insurer funding and direct consumer funding will be required to support these models as they become embedded into the system.

Policies related to the specific funding arrangements for these services will likely be further developed and refined by the PHI sector over the coming years. As a result, it may be that there are aspects that require additional regulation to support consumer choice and access – in which case it is possible that arrangements similar in nature to default benefits will be required.

Appendix A Reliance and limitations

This report was prepared at the request of the Australian Government Department of Health and Aged Care (hereafter "the Client") solely for the purposes of conducting an independent study on private health insurance minimum and second-tier default benefits, including the administrative, operational, and regulatory settings associated with the default benefits (hereafter "the Project") in accordance with the engagement agreement dated and signed 17 March 2022 and it is not appropriate for use for other purposes.

No representation, warranty or undertaking is made or liability is accepted by Ernst & Young as to the adequacy, completeness or factual accuracy of the contents of our report. In addition, we disclaim all responsibility to any party for any loss or liability that any party may suffer or incur arising from or relating to or in any way connected with the contents of our report, the provision of our report to any party or the reliance upon our report by any party.

Analysis presented in the report has been limited by time, scope and data availability. In carrying out our work and preparing this report, Ernst & Young has worked solely on the instructions of the Client, and has not taken into account the interests of any party other than the Client. The report has been constructed based on information current as of 2 December 2022, and which have been provided by the Client. Since this date, material events may have occurred since completion which is not reflected in the report.

Our report is based on information and data supplied by the Client and other stakeholders through the consultation process. We have not sought to verify the accuracy of data or information provided to us by the Client and other stakeholders.

Members of EY staff are available to explain any matters presented herein to aid further understanding of the report. Ernst & Young does not accept any responsibility for use of the information contained in the report and make no guarantee nor accept any legal liability whatsoever arising from or connected to the accuracy, reliability, currency or completeness of any material contained in this report. Ernst & Young and all other parties involved in the preparation and publication of this report expressly disclaim all liability for any costs, loss, damage, injury or other consequence which may arise directly or indirectly from use of, or reliance on, the report.

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Appendix B Glossary and abbreviations

Term	Definition
ABS	Australian Bureau of Statistics
ACSQHC	Australian Commission on Safety and Quality in Health Care
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification is a casemix classification used for activity based funding, clinical management and other purposes.[63]
APRA	Australian Prudential Regulation Authority
AWE	Average Weekly Earnings
Consumer	A person who has private health insurance
CPI	Consumer Price Index
Contract status	Refers to whether a contract exists between the hospital at which a patient is admitted and the patient's insurer or not
DRG/AR-DRG	Australian Refined Diagnosis Related Groups is a classification system, that provides a clinically meaningful way to relate or group the number and type of patients treated in admitted acute episodes of care to the resources required in treatment. DRGs group patients with similar diagnoses requiring similar hospital services.[64]
The Department	The Australian Government Department of Health and Aged Care
Front-end deductibles	An amount, agreed to in a private health insurance policy, that is paid by the consumer towards the cost of hospital treatment, in exchange for lower premium costs. These take the form of either policy excesses or co-payments (or both).
FY	Fiscal Year. For example, FY21 refers to the Fiscal Year 2021, commencing 1 July 2020, and concluding on 30 June 2021.
Geography	Refers to the geographical location of the hospital or patient, split into either: ► Modified Monash Model (MMM) - a Department model that measures an area according to geographical remoteness and town size. ► Remoteness Area - an ABS structure that divides Australia and the States and Territories into 5 classes of remoteness on the basis of their relative access to services.
GP	General Practitioner
HCP1	Hospital Casemix Protocol 1. Data submitted by private health insurers to the Department for each episode of admitted hospital treatment for which a benefit has been paid
HCP2	Hospital Casemix Protocol 2. Data submitted by private health insurers to the Department for hospital treatment they have paid benefits for, which do not qualify as an "episode of admitted patient care"
HITH	Hospital in the home. Defined by the AIHW[65] as the provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Note that Hospital Substitute Treatment is separately defined in the *Private Health Insurance Act (2007)* as a type of general treatment that substitutes for an entire episode of hospital treatment whereas, for the purpose of this study, HITH is considered to be a component of an admitted hospital episode. HITH can be funded by private health insurers via hospital contracting

[63] Independent Hospital and Aged Care Pricing Authority. 2021. Resources. Available at: https://www.ihacpa.gov.au/resources/australian-national-subacute-and-non-acute-patient-classification-version-50

[64] Independent Hospital and Aged Care Pricing Authority. Admitted acute care. Available at: www.ihacpa.gov.au/health-care/classification/admitted-acute-care/ar-drgs

[65] Australian Institute of Health and Welfare. Hospital-in-the-home care. Available at: www.meteor.aihw.gov.au/content/327308

Term	Definition
Hospital category	Refers to the categories defined in Private Health Insurance (Benefit Requirements) Rules 2011 Schedule 5 Clause 1A(7). These are the categories A to G, defined by the service provided, size of hospital and/or length of stay
Hospital type	Refers to the type of hospital, grouped into public hospital, private overnight hospital and private day hospital
IFC	Informed financial consent
IHACPA	Independent Health and Aged Care Pricing Authority
Ipsos Reports	Consumer insight reports relating to the healthcare sector published by Ipsos in 2021
LHC	Lifetime Health Cover
Minimum benefits	The lowest amount that an insurer is required to pay for a hospital admission included in a policy.
MBS	Medicare Benefits Schedule
MLS	Medicare Levy Surcharge
National safety and quality accreditation	Accreditation to the NSQHS Standards required for all public and private hospitals.
NEP	National Efficient Price. Determined by IHACPA each year. Determines the amount of Commonwealth Government funding for public hospitals and provides a price signal or benchmark about the efficient cost of providing public hospital services.
NHRA	National Health Reform Agreement. An agreement between the Government and all State and Territories, committing to improve health outcomes for Australians.
NPBC	National Procedure Banding Committee. A steering committee comprising of private hospital and private health insurer nominees that oversees the management, maintenance and update of procedure bands.
NSQHS	National Safety and Quality Health Service Standards
NWAU	National Weighted Activity Unit. A measure of health service activity, against which the NEP is paid.
Patient	A person who receives health services
Payer identifier	Refers to an indicator within the PHDB data that provides information about the way in which the separation is funded
PBS	Pharmaceutical Benefits Scheme
Per Diem	For each day. Metric of duration used in contracting for payments based on the length of stay in an overnight hospital.
PHDB	Private Hospital Data Bureau. Data submitted to the Department by private hospitals and day facilities for each episode of hospital treatment for admitted patients
PHI	Private health insurance
PHI default benefit arrangements *or* **default benefit arrangements**	Refers to minimum benefits and second-tier default benefits but captures all associated rules, such as eligibility and the calculation process, as well as the schedules of rates
PL	Prostheses List
PREMs	Patient-Reported Experience Measures- a questionnaire that measures the patient's perceptions of their experience whilst receiving care to facilitate quality improvement.
PROMs	Patient-Reported Outcome Measures- a questionnaire that provides way of measuring health outcomes from the patient's perspective to support person-centred and value-based care.
RE	Risk Equalisation – a mechanism, defined in the *Private Health Insurance (Risk Equalisation Administration) Rules 2015*, that supports community rating in PHI. It involves pooling and sharing risks between insurers based on the age mix of each insurer's claimants and high cost claims incurred by the insurer.

Term	Definition
Restricted cover	Restricted cover only offers partial benefits for specified treatments or services. For hospital benefits, this partial benefit is at least the minimum default benefit amount.
Second-tier default benefits	A benefit amount for second-tier eligible hospitals that uses no less than 85% of the average contracted rate for "equivalent episodes".
Second-tier schedules	The yearly PHI calculated rate for each episode of hospital treatment based on its negotiated contractual agreements in force on 1 August, as described in Schedule 5 of the *Private Health Insurance (benefit Requirements) Rules 2011*
SRG	Service Related Group. Categorises admitted patient episodes into groups representing clinical divisions of hospital activity, based on aggregations of Australian refined diagnosis-related groups (AR-DRG).

Appendix C Information collection and analysis

C.1 Methods informing this report

In developing this report, we drew upon a combination of stakeholder consultation, data analysis and literature reviews as described in Figure 40.

Figure 40: Summary of methods used to inform this report

Interviews 	Interviews were conducted via Microsoft Teams with representatives spanning private day hospitals and small facilities, regional providers, large private overnight hospitals, public hospital funding teams at the Department and private health insurers and peak bodies. In these interviews, we explored stakeholder perspectives on the current arrangements and potential future reform Opportunities, including: ► The broader administrative and operational settings such as eligibility for default benefits. ► The contracting environment and conditions between private insurers and hospitals. ► The impact of different reform Opportunities on various stakeholder groups. Details of the participants in these interviews are given in Section C.2 below.
Workshops: First and second round 	Two rounds of workshops were conducted. ► **Round 1 -** Three virtual workshops were conducted via Microsoft Teams for day hospitals and small facilities, larger overnight private hospitals, and private health insurers. ► **Round 2 -** Four virtual workshops were conducted via Microsoft Teams for day hospitals, overnight private hospitals, private health insurers and State and Territory Jurisdictions. An additional combined stakeholder workshop with peak body participation was also conducted. The workshops provided an opportunity to further test the key reform Opportunities under consideration.
Consultation paper 	A consultation paper containing 37 questions designed to collate stakeholder perspectives on both the current arrangements and sentiment towards potential Opportunities for reform. In total 43 submissions were received across all stakeholder groups.
Literature and legislative review 	A qualitative analysis was undertaken, including a critical review of the *Private Health Insurance (Benefit Requirements) Rules 2011*, acknowledging the strengths, limitations, and areas of ambiguity of the legislation. The review of the Benefit Requirements included assessment of the calculation methodology including how accommodation expenses are covered, hospital eligibility requirements for minimum and second-tier default benefits, understanding categorisation of different procedure types and hospital categorisation. EY have also critically reviewed a broad range of literature including, but not limited to research, previous work conducted in this area, committee papers, issues papers, international research papers and IPSOS consumer insights.
Data analysis 	Data analysis was conducted, alongside stakeholder consultation and the literature review, to understand the current state of default benefit arrangements. The aim of this analysis was to form an evidence-based view, understand current trends around default benefit arrangements, and assess whether the data corroborates the views obtained through stakeholder consultation. More detail on the data analysis is outlined in Appendix C.3. Further analysis was undertaken in relation to some of the Opportunities put forward in Section 4, to support and provide quantitative context on these Opportunities. The key data sets that have been analysed are: ► HCP1, HCP2, PHDB. ► Hospital data held by the Department, including geographic location, number of beds and opening date. ► Agreement Hospitals matrix on data.gov.au. ► Private hospital second-tier category lists. ► Commonwealth declared hospitals list. ► Australian Taxation Office (ATO) individual sample files, comprising a 2% sample of the Australian population with characteristics such as geographic region, income and whether the individual holds PHI. ► Australian Prudential Regulation Authority (APRA) quarterly PHI statistics. ► Gold, Silver, Bronze and Basic participation data received from the Department.

We applied our analysis to the current and potential future Opportunities for default benefit arrangements using the assessment criteria introduced in Section 2.4.3. The assessment criteria for this study were designed in consultation with the Department and stakeholders with the intention that they support the Department's higher-level PHI policy study objectives relating to the affordability and value of PHI, participation in PHI, and the sustainability of PHI, supporting PHI consumer benefits.

The agreed assessment criteria are shown in Figure 41, with a detailed description of each criterion and supporting metrics provided in Table 28.

Figure 41: Assessment criteria

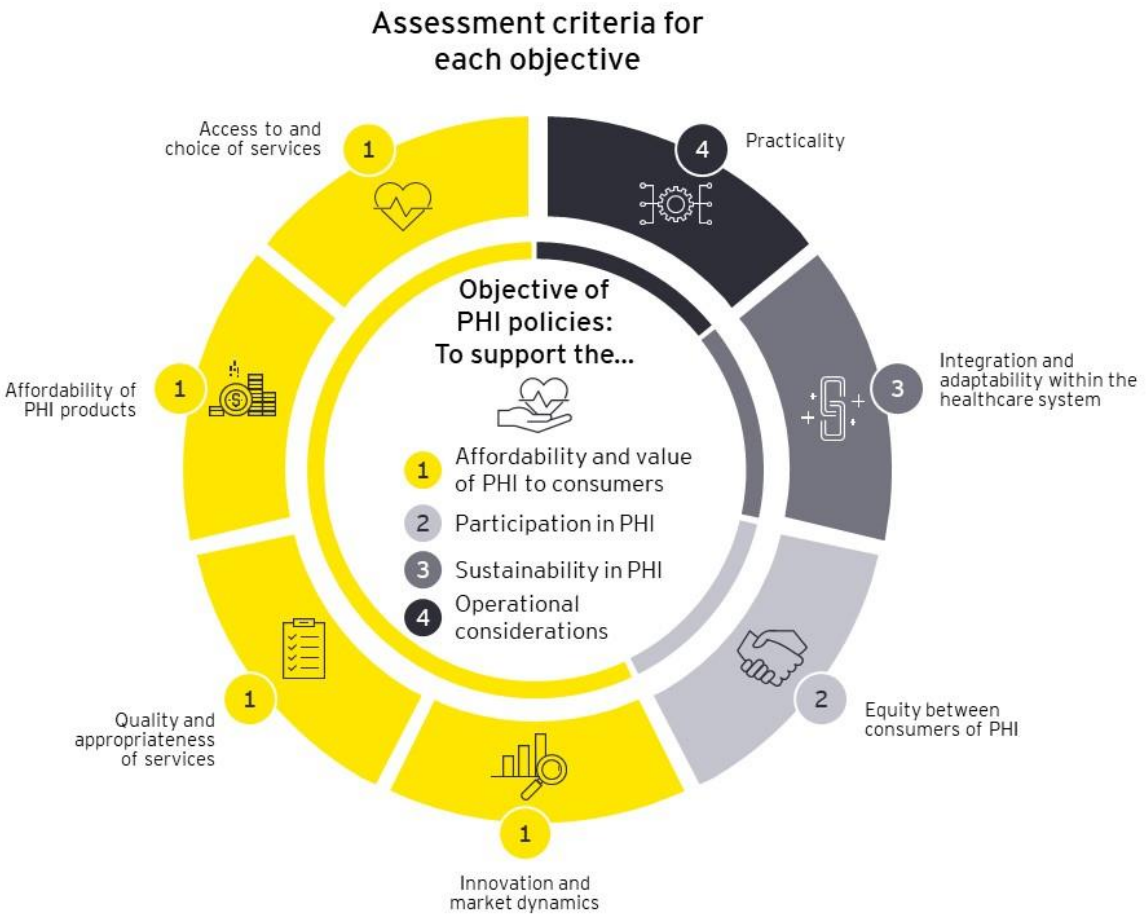


Table 28: Assessment criteria

Objective of PHI policies	Assessment criteria	Criteria description applicable to default benefit arrangements
Affordability and value of PHI to consumers	Access to and choice of services	► Supports access to appropriate insurer-funded healthcare services including point at which choice is exercised, without excessive hospital out-of-pocket costs or travel, access to appropriate information and tools support to make informed decision. ► Policyholders irrespective of insurer should have broadly equivalent access.
	Affordability of PHI products	► Cost of care is efficient and equitable across policyholders with respect to location and type of care.
	Quality and appropriateness of services	► Eligibility requirements for second-tier default benefits ensure patients can have confidence about the quality of care received in regard to outcomes, standards and processes.

Objective of PHI policies	Assessment criteria	Criteria description applicable to default benefit arrangements
		► Ensuring safety and quality are the primary purposes of the ACSQHC and State and Territory licensing/registration requirements, and any observed safety and quality issues relating to default benefit-funded services should be considered in the context of the national safety and quality standards and framework.
	Innovation and market dynamics	► Supports affordability of PHI through claims efficiency resulting from market dynamics. ► Service delivery continues to evolve through innovation.
Participation in PHI	Equity between consumers of PHI	► Price of PHI product and value of services offered reaches all Australians who could benefit from PHI.
Sustainability of PHI	Integration and adaptability within the healthcare system	► A wide range of services are insurer funded and integrate with the public and primary health system to provide continuity of care. ► Enable fair bargaining between hospitals and insurers. ► Availability, accessibility and nature of services is able to evolve with changing demand or expectations of the public, as well as shocks such as pandemics.
Operational considerations	Practicality	Considerations for Opportunities: ► Political appetite for change. ► Sufficient stakeholder buy-in. ► Implementation timeframes. ► Implementation costs of a change to policy are feasible. ► Limited/manageable unintended consequences.

These criteria were selected to ensure coverage of the higher-level objectives for all Australian Government PHI policies, but also to align with our understanding of the policy intent behind default benefit arrangements themselves. Although no policy intent has been explicitly articulated in PHI legal arrangements, an understanding of the broad areas of intent can be inferred from the design of a tiered legislated benefit amount structure with different conditions attached to those tiers.

C.2 Stakeholder consultations

Consultation paper

A stakeholder consultation paper was publicly released by the Department in August 2022. The consultation paper provided an opportunity for external stakeholders to give feedback on the Opportunities developed to date and comment on other areas of the study. The Opportunities defined in this report were further developed from the Opportunities presented in the consultation paper upon review of feedback received via the consultation paper, second round stakeholder consultations and in conjunction with ongoing data analysis. Table 29 below captures all 39 submissions received from the consultation paper.

Table 29: List of consultation paper responses

Organisation	Stakeholder type
Acurio Health	Day Hospital
Adelaide Ambulatory Care	Day Hospital
Canberra Microsurgery	Day Hospital
Central Day Surgery	Day Hospital
Hospitals Australia East Melbourne Specialist Day Hospital	Day Hospital
Focus Eye Centre	Day Hospital
Harley Day Surgery	Day Hospital
Icon Cancer Centre	Day Hospital

Organisation	Stakeholder type
Melbourne Day Surgery	Day Hospital
Mogo Day Surgery	Day Hospital
Pacific Private Day Hospital	Day Hospital
ParkView Day Surgery	Day Hospital
Specialist Surgicentre	Day Hospital
Sydney Dermatology Group	Day Hospital
Toowoomba Day Hospital	Day Hospital
Virtus Health	Day Hospital
Day Hospitals Australia	Day Hospital Peak Body
Australian Commission on Safety and Quality in Health Care (ACSQHC)	Government
Commonwealth Ombudsman	Government
Department of Veterans' Affairs (DVA)	Government
Health QLD	Government
Health SA	Government
Ramsay Connect	Hospital provider – Other
Australian Medical Association (AMA)	Medical Practitioners Peak Body
Australian Private Hospitals Association (APHA)	Overnight and Day Hospital Peak Body
Healthscope Aurora Healthcare	Overnight Hospital
Nexus Hospitals	Overnight and Day Hospital group
Catholic Health Australia (CHA)	Overnight and Day Hospital group
Sole-vita Aurora Healthcare	Overnight and Day Hospital
Spendelove	Overnight Hospital
Wyvern Private Hospital	Overnight Hospital
Australian Health Service Alliance (AHSA)	Private Health Insurer Alliance
BUPA	Private Health Insurer
Defence Health	Private Health Insurer
HBF	Private Health Insurer
Members Health Fund Alliance (MHFA)	Private Health Insurer Peak Body
Mildura Healthfund	Private Health Insurer
Private Healthcare Australia (PHA)	Private Health Insurer Peak Body
Mind Australia	Provider - Other

Individual consultations and workshops

The first and second round of stakeholder interviews and workshops, outlined in Table 30 and Table 31 respectively below, were conducted to test the identified potential reform Opportunities with stakeholders and explore the key areas discussed above. Feedback from the first and second round of consultations was considered in conjunction with the consultation paper feedback and data analysis to refine the proposed reform Opportunities.

Table 30: First Round Stakeholder Consultation List

Workshops round 1	Date of consultation
Private health insurers	17th May 2022
Private Hospitals	18th May 2022
Day Hospitals	20th May 2022
Jurisdictions	25th May 2022

Individual consultations round 1	Date of consultation
Day Hospitals Australia (DHA)	29th April 2022
Australian Private Hospitals Association (APHA)	2nd May 2022
Australian Health Service Alliance (AHSA)	3rd May 2022
Catholic Health Australia (CHA)	4th May 2022
Australian Regional Health Group (ARHG)	4th May 2022
Private Healthcare Australia (PHA)	5th May 2022
Australian Medical Association (AMA)	5th May 2022
Members Health Fund Alliance (MHFA)	11th May 2022
National Procedure Banding Committee (NPBC) - NIB representative	13th May 2022
Consumers Health Forum of Australia (CHF)	18th August 2022

Table 31: Second Round Stakeholder Consultation List

Workshops round 2	Date of consultation
Jurisdictions	26th October 2022
Private health insurers	2nd November 2022
Private Hospitals	8th November 2022
Day Hospitals	8th November 2022
Combined stakeholders	14th November 2022

Individual consultations round 2	Date of consultation
Medical Technology Association of Australia (MTAA)	1st July 2022
Australian Institute of Health and Welfare (AIHW)	7th July 2022
Medibank	7th September 2022
Ramsay Health	14th September 2022
Independent Health and Aged Care Pricing Authority (IHACPA)	17th October 2022
Healthscope	16th November 2022
Consumers Health Forum of Australia (CHF)	23rd November 2022

C.3 Data analysis

The focus on this stream over the course of this study included:

- Analysis in alignment to the study's data analysis plan, as developed by EY to inform our assessment of the current state of default benefit arrangements.
- Additional analysis to provide context and rational for the potential Opportunities for reform.

The data analysis focused on minimum and second-tier default benefits arrangements is largely reliant on the data sources collected by the Department for private patients and private hospitals, consisting of HCP1, HCP2, PHDB. These are data files submitted by private health insurers and private hospitals under the *Private Health Insurance Act 2007*.

Data analysis plan

This data analysis plan aimed to provide an overview of our approach in supporting the review of the current arrangements, including:

- The data sources used.
- The structure of the data analysis to be performed.
- How the analysis links to the assessment criteria.

The analysis performed was based on available data and project timeframes, as well as our assessment of our ability to identify casual links, or lack thereof, between metrics and funding arrangements, that is, contracted versus default benefits. The data analysis plan is included in the following pages.

Phase 1: Review the current arrangements

1.1 High-level statistics providing context on the value of PHI

Question	Metric	Data	Disaggregations
What is the take-up of PHI?	PHI participation	► ATO individual sample files	► Participation by geography and income over time
		► APRA quarterly PHI statistics ► Gold Silver Bronze Basic (GSBB) participation data received from the Department	► By product tier (GSBB) and geography
How many separations/services are funded by PHI?	Number of separations/services funded by insurers	► HCP1 and HCP2	► Utilisation by geography over time
What are the total benefits paid by PHI?	Total benefits paid by insurers	► HCP1 and HCP2	► Total benefits by geography over time
What are the total charges for private hospital separations that are self-funded?	Total benefits from self-funded separations	► PHDB	► By geography based on hospital location and hospital type over time
How have premium prices changed over time?	Premium price changes	► Department of Health and Aged Care published annual price changes in PHI premiums	► By insurer over time
Where are the private hospitals geographically located?	Distribution of private hospitals around Australia	► Based on existing Department of Health and Aged Care analysis and HERD data	► By hospital category
What are the current attitudes about PHI among consumers?	Population attitudes	► Ipsos reports	► Not applicable

Phase 1: Review the current arrangements

1.2 Overview of current private hospital funding arrangements by different contract arrangements

An overview of the current private hospital funding arrangements will provide context for our study, as well as observations for reports and stakeholder consultation paper.

Question	Metric	Data	Disaggregations
What do the hospital contracting arrangements currently look like between hospitals and insurers? **How has this changed over time?**	Proportion of separations/services funded by contracts, minimum benefits and second-tier default benefits	► HCP1 and HCP2	► By geography ► By hospital type/categories ► By service type ► By year
	Proportion of benefits, out-of-pocket and total charges funded by contracts, minimum benefits and second-tier default benefits	► HCP1 and HCP2	► By geography ► By hospital type/categories ► By service type ► By year
	Number of separations/services by hospital, insurer and hospital contract status	► HCP1 and HCP2	► By year ► By service type ► By hospital type/categories
	Proportion of second-tier eligible hospitals	► Commonwealth Declared Hospitals list ► Private Hospital Second-tier Category Lists	► By geography ► By hospital categories ► By year

Assessment criteria	Question	Metric	Data	Disaggregations
Access to and choice of services	**Where are private hospitals located?**	Number of hospitals per population	► Hospital geographic data provided by the Department ► ATO population statistics	► Contract status ► By geography ► By hospital categories
	How are default benefits supporting the geographical access to hospitals?	Travel distance between hospital and residence of patient	► HCP1 and HCP2	► Contract status ► By geography ► By service type
	What services are being accessed by patients?	Count of service type	► HCP1 and PHDB	► Contract status/payer identifier ► By geography ► By hospital categories
	How does the accessibility of insured services affect take-up of PHI?	Participation in PHI	► ATO individual sample files	► By geography and income
Affordability of PHI products	**How are out-of-pocket costs affected by contracting arrangements?**	Out-of-pocket costs	► HCP1 and HCP2	► Contract status ► By geography ► By service type ► By hospital/medical component
	How are consumers valuing PHI?	PHI participation	► APRA quarterly PHI statistics ► Gold Silver Bronze Basic (GSBB) participation data received from the Department	► By product tier (GSBB) and geography over time
Quality and appropriateness of services	**What is the frequency of readmissions for private patients?**	Rate of readmissions within 28 days	► HCP1 and PHDB	► Contract status/payer identifier ► By hospital category ► By service type
	What is the frequency of hospital acquired complications?	Rate of healthcare-associated infections	► AIHW	► Contract status ► By hospital category
	What is the frequency of low value / unwarranted variations in care?	Variations in healthcare use	► Atlas of Variation Series	► Contract status ► By hospital type
	How often do the intended and actual mode of separation differ?	Rate of different intended and actual modes of separation	► HCP1 and PHDB	► Contract status/payer identifier ► By hospital type

Assessment criteria	Question	Metric	Data	Disaggregations
				► By service type
Innovation and market dynamics	**What is the frequency of new and innovative services being offered?**	Frequency of HITH and hospital substitute treatment (HST) services	► HCP1 and HCP2	► Contract status ► By hospital category ► By service type ► By geography
	How are market dynamics affecting prices of services?	Changes in benefits paid over time of high volume service types	► HCP1 and HCP2	► Contract status ► By geography ► By hospital type
Integration and adaptability within the healthcare system	**How often are private patients treated in public hospitals? How are they funded?**	Frequency and total benefits of private insurance funded separations/services in public hospitals	► HCP1 and HCP2	► By geography
Equity between consumers of PHI	Equity is assessed in the above criteria by evaluating, in particular, the access and affordability of services for all consumers, regardless of location and service type required.			

Data governance and access arrangements

The data governance and access arrangements in place for the data analysis are noted in this Section. The transfer conditions are:

- Creation of summary graphs within the Department of Health and Aged Care (the Department) environment.
- Transfer of the summary graphs from the Department environment to the EY study environment for input to the EY Private Hospitals default benefits arrangements study. Transfer of summary graphs via the Department-EY secure SharePoint site (department environment) or via email from Health Outlook to EY email system.
- No summary graph transferred to identify or allow for the identification of an individual insurer, hospital, or business (corporate) entity.
- No release of the EY study prior to Department consideration and approval.
- Suppress cells where the number of hospitals (as defined by provider numbers) reporting at least one admission/service is less than 3, or the number of admissions/services is less than 10.

Analyses beyond the scope of this study

A number of analyses were beyond the scope of this study. These include:

- Detailed fee benchmarking.
- Detailed comparison of costs in the provision of care.
- Detailed analysis of second-tier benefit schedules.

Appendix D Calculation of second-tier default benefits

The calculation of second-tier default benefits is determined under the *Private Health Insurance (Benefit Requirements) Rules 2011* (Cth), made under item 3A of the table in section 333-20 of the *Private Health Insurance Act 2007*. The formula is detailed within Clause 3 of Schedule 5.

The second-tier benefit is calculated as 85% of:

$$R_j = \frac{\sum_{i=1}^{n} R_{ji}}{n}$$

where:

- j = group of equivalent episodes of hospital treatment under the insurer's negotiated agreements
- i = group of the insurer's negotiated agreements in force on 1 August of the first year with comparable private hospitals in the State
- n = number of the insurer's negotiated agreements in force on 1 August of the first year with comparable private hospitals in the State
- R_{ji} = charge for episode of hospital treatment type j in the negotiated agreement i
- R_j = average charge for episode of hospital treatment type j

The charge R_{ji} will include the sum of the amount payable by the insurer under that insurer's negotiated agreement and any excess or co-payment amounts payable by members, in accordance with the insurer's rules, and must not include any charges:

- Referred to in the insurer's negotiated agreements for prostheses, and
- That are minimum benefits for prostheses as specified
- Referred to in the insurer's negotiated agreements for hospital treatment provided to nursing-home type patients

If there are less than five negotiated agreements within a particular category of comparable hospitals in a State, then all of the insurer's negotiated agreements with all classes of private hospitals in that State that provide for an equivalent episode of hospital treatment are to be used to calculate the minimum benefit.

If the benefit calculated is below the minimum default benefit amount or an amount for the hospital treatment cannot be worked out in accordance with these rules, the benefit paid is the minimum default benefit amount.

Appendix E Technical appendix

This Section provides detail on the technical components of the data analysis, including:

- Data inputs and preparation steps.
- Known relevant data quality issues within HCP1 and implications for analysis.
- Relevant data quality issues within PHDB and HCP2.
- Recommendations for data improvements.

E.1 Data inputs and preparation steps

This study involved the analysis of HCP1, HCP2 and PHDB data. The analysis in this report is based on copies of these datasets, extracted on 14 September 2022.

There were other data sources identified but not available for this study. These consist of: complete second-tier default benefit schedules and business rules from all insurers, and contracts and accompanying terms and conditions between hospitals and insurers.

Exclusions

HCP1 and PHDB have been cleansed by the Department, which involves the exclusion of some records from the underlying data and are outlined in the HCP Annual report[66] and PHDB Annual Report.[67] The exclusions outlined in the HCP Annual Report was also applied to HCP2. Further exclusions were applied to PHDB as advised by the Department, where separations had certain care types and the charge exceeds $500,000.

Data preparation

Following advice from the Department, the hospital type for a few providers in HCP1, HCP2 and PHDB was changed from public to a private other hospital type. These private hospitals predominantly provide public services and had been categorised as public hospitals by the Department to reflect AIHW's categorisation of these hospitals. Also, the hospital contract status variable for all public hospital separations in HCP1 and HCP2 was updated to "not contracted", as contracting and second-tier default benefits do not apply in the public hospital setting.

Assumptions for merging with supplementary data

Supplementary datasets were merged with HCP1 for certain outputs included in this report. This process often required assumptions to ensure appropriate matching. Supplementary datasets were also merged to PHDB and HCP2. However, given the outputs in this report are focused on HCP1, Table 32 outlines the assumptions and implications for HCP1 only.

Table 32: Assumptions used for merging HCP1 with supplementary data

#	Supplementary data	Assumptions	Implications for analysis
1	**Hospital MMM**	A small number of hospitals share provider ID numbers. Where there was different MMM classifications for a provider ID, the maximum MMM was mapped to the provider ID.	Given that the categorisations shown in relevant outputs are major city (MM1) and not major city (MM2-7), this assumption does not materially affect the results shown.

[66] Department of Health and Aged Care. 2021. Hospital Casemix Annual Reports. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

[67] Department of Health and Aged Care. 2021. Private Hospital Data Bureau (PHDB) Annual Reports. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-PHDBAnnualReports

#	Supplementary data	Assumptions	Implications for analysis
2	**Hospital category**	No list directly related to the 2018-19 category year was provided. Instead, the Declared Hospitals list as at 3 January 2019 was provided by the Department. The categories in this list were used, with any gaps filled using the 2019-20 list.	No material implications for analysis
		The hospital category was assumed to refresh each August. An exception to this assumption was the July 2014 data, which was assumed to take the 2014-15 category list due to data availability.	No material implications for analysis
		Where there was a different hospital category for a provider ID, the maximum category was taken i.e. the higher category letter of the two.	As only 4 providers IDs in the category lists were duplicated, this assumption does not materially affect the results shown.
		A hospital category was not available for some provider IDs within HCP1. If the hospital type of these provider IDs was public, it was assigned a "P" category. Otherwise, the provider ID was assigned an "undefined" category.	0.1% of separations occur at these provider IDs with an undefined category and does not materially affect the results shown.
3	**Postcode to longitude/latitude mapping**	The longitude and latitude of the centroid of each patient's residential postcode was mapped onto HCP1. The data source provides a longitude/latitude for each locality within a postcode. Where there were multiple values for a single postcode and state, the average longitude and latitude was used.	This data was used in the distance analysis. This assumption is not expected to materially affect this analysis.
4	**Postcode to MMM mapping**	The MMM corresponding to each patient's residential postcode was mapped onto HCP1. The data source provides the MMM classification for each locality within a postcode. Where there were multiple MMM classifications for a single postcode and state, the mode MMM was mapped. If there was more than 1 mode, the maximum MMM of the modes was mapped.	Given that the categorisations shown in relevant outputs are major city (MM1) and not major city (MM2-7), this assumption does not materially affect the results shown.

E.2 Known data quality issues within HCP1

The analysis of data and information is limited by the availability and reliability of data. Default benefit arrangements is a complex system and all aspects of the system, and its impacts are not always captured in the data. The analysis included in this report is based primarily on the HCP1 data, and data quality issues within this underlying dataset, as outlined in Table 33 impact the interpretability in the results.

Table 33: Known data quality issues within HCP1

#	Type	Issue	Implications for analysis
1	**Completeness of data**	Not all private patient separations are reported for 2020/21. ► There is a large decline in 2020/21 separations and medical services due to missing data. ► The Department undertakes HCP1 compliance activity. It was noted by the Department that current HCP1 data compliance action is in progress.	The reader should refer to Table 3 from the HCP Annual Report for completeness rates and consider this when interpreting the enclosed analyses.
2	**Inconsistencies in data collected**	► There may be variation in admission practices between hospitals. ► A small number of hospitals include non-admitted services.	This limitation should be considered when interpreting the enclosed analyses.

#	Type	Issue	Implications for analysis
3	**Data validity and quality issues in benefits and charges**	► Some medical benefit and charge values have been flagged as not valid. ► There are charges/benefits reported in the Episode Record without accompanying data in corresponding records, e.g. Medical and Prostheses, particularly in public hospitals. ► It is reported that insurers do not receive claims information for charges that are raised by the hospital that are not covered by the patient's hospital insurance policy.	When looking at medical and total benefits charges and out-of-pocket costs, we will only look at separations that have a valid medical record.
4	**Data quality issues in hospital contract status**	There is general uncertainty around the quality of the hospital contract status data item in certain circumstances. It is noted that: ► "Bulk" refers to a Prospective Payment Model arrangement in South Australia. ► "A hospital with which the Insurer does not have a contract." seems to refer to separations funded by minimum benefits in public hospitals, but not in private hospitals. It is not fully clear what the contracting arrangement is when this value is coded within private hospitals.	As there are very few separations in each financial year that report a "bulk" contract status, we will exclude these separations from reporting. The Department has requested that HCP1 data providers implement appropriate quality assurance data checks for the contract data item. Further investigation is currently being conducted by the Department in interpreting the "a hospital with which the Insurer does not have a contract" value for private hospital separations, and how this should be reported.
5	**Data quality issues in public hospitals**	► A large proportion of separations have "other" or "unknown" care types. ► A large proportion of separations have an "error" DRG due to missing clinical data. ► Proportional mix of values are inconsistent with the admitted patient care data maintained by the AIHW, for variables such as care type, urgency of admission and separation mode. ► Jurisdiction stakeholders have stated that some public hospitals will absorb any difference between the hospital charge and hospital benefit to avoid charging patients out-of-pocket costs. This amount may be calculated in HCP1 as out-of-pocket costs, but is not paid by the patient.	These limitations should be considered when interpreting the enclosed analyses, particularly any outputs focused on public hospitals. Where service type analyses will be conducted, error DRGs were excluded from the analysis. Accordingly, limitations should be considered when interpreting the analysis on hospital out-of-pocket costs paid by patients in public hospitals.

E.3 Data quality issues with PHDB and HCP2

We were supplied with PHDB data by the Department to consider for analysis as part of this study. We compared the volumes in the PHDB data with that in HCP1 as a validation exercise and noticed some discrepancies. In Table 34, we compared volumes between:

► Payer identifier of "Insured with agreement with hospital" in PHDB **and** Hospital contract status of "a hospital with which an insurer has a contract" in private hospitals in HCP1.

► Payer identifier of "Insured with no agreement with hospital" in PHDB **and** Hospital contract status of "a hospital is paid under second-tier benefit arrangement" in private hospitals in HCP1.

The first comparison is roughly similar, but there is some variation when comparing "no agreement" and "not contracted or second-tier".

Table 34: Comparison of volumes reported in HCP1 and PHDB

		FY15	FY16	FY17	FY18	FY19	FY20
PHDB	Insured with agreement	2,938,402	3,133,082	3,264,473	3,321,896	3,463,288	3,221,609
HCP1	Contracted in private hospitals	3,102,933	3,229,179	3,298,683	3,392,214	3,449,726	3,299,765
	Difference	164,531	96,097	34,210	70,318	-13,562	78,156
	Difference as percentage of HCP1 volume	5.30%	3.00%	1.00%	2.10%	-0.40%	2.40%
PHDB	Insured with no agreement	322,079	309,881	286,796	279,833	255,636	221,037
HCP1	Not contracted/second-tier in private hospitals	103,922	118,047	131,145	133,260	99,858	95,963
	Difference	-218,157	-191,834	-155,651	-146,573	-155,778	-125,074
	Difference as percentage of HCP1 volume	-209.90%	-162.50%	-118.70%	-110.00%	-156.00%	-130.30%

Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022), Pre-processed PHDB data supplied by the Department (extracted 14 Sep 2022)*

PHDB also reports separations in private hospitals with a payer identifier of "*self insured*", that is, funded by the patient. We were interested in comparing metrics analysed within HCP1 for insured separations against self-insured patients in PHDB. We were advised that, when compared to AIHW data, self-insured separations are overreported in PHDB. Due to our reliance on variables reflecting the contracting status for this study, we have not included the results of analyses performed on PHDB in this report.

We were also supplied with HCP2 data to consider for analysis as part of this study. This data is supplied by insurers to the Department in respect of hospital treatments they have paid benefits for, which do not qualify as an "episode of admitted patient care" and are therefore out of scope of HCP1. HCP2 contains data on services (that qualify as hospital treatment) provided to patients who are not admitted to hospital.[68]

However, many of the service descriptions included in the HCP2 data specifications may be services that are covered under general treatment, and we were unable to gain a clear understanding of the nature of services reported in this dataset. Further to this, we were advised by the Department that HCP2 data is currently not used for any public reporting due to the unavailability of any comparative data to assess HCP2's quality and completeness. Due to these uncertainties around HCP2 data, we have not included the results of analyses performed on HCP2 in this report.

E.4 Recommendations for data improvements

Over the course of this study, we have identified recommendations for data improvements to the available data to allow for more useful insights from the data. Some stakeholders also expressed their recommendations for possible improvements.

Table 35: Recommendations for data improvements

#	Recommendation	Reason
1	**We recommend that either a new variable is introduced within HCP1/2 or the existing hospital contract status variable is redefined to capture the funding arrangement that applies to each separation. In this recommendation, the variables (both existing and/or new) should have a clear definition that is mutually exclusive.**	Stakeholders have suggested that the current hospital contract status variable refers to the broad existence or non-existence of a contract between a hospital and insurer. Some contracts exclude certain services, and the hospital would receive a default benefit for this service, despite the existence of a contract.

[68] Department of Health and Aged Care. 2022. HCP data specifications – HCP2 – Insurer to Department – 2022-23. Available at: www.health.gov.au/resources/publications/hcp-data-specifications-hcp2-insurer-to-department-2022-23

#	Recommendation	Reason
		This recommendation would allow for more reliable analyses on the separations where a default benefit is paid, including volume, types of services and out-of-pocket costs paid. In addition, there is some ambiguity in the values within the hospital contract status variable. Under the current data specifications for HCP, hospitals that do not have a contract with an insurer and are second-tier funded could fall under "a hospital with which the insurer does not have a contract" as well as "a private hospital is paid under second-tier default benefit arrangement".
2	**We recommend that any new facilities and campuses are identified by a unique provider ID.**	Currently, there are several provider IDs that are shared between two private facilities. These do not follow the current intent of hospital declaration and provider numbers, such that one declaration should identify one hospital. It also impacts data submissions and second-tier categorisation. However, there is no legislative condition to require each hospital have their own provider number and there would be significant implications in changing a provider number for an established hospital. We recommend that any new facilities are required to be identified by a unique provider ID to allow for a clearer analysis of activity in each facility.
3	**We recommend that hospitals are required to report updated version of AR-DRG codes and Australian national sub-acute and non-acute patient (AN-SNAP) classifications.**	During our analysis, we noticed the large volume of separations being reported under older versions of both AR-DRG codes and AN-SNAP codes. We were unable to map the reported AN-SNAP classifications to the recent version due to relatively significant changes from previous versions. This limited our analysis of subacute and non-acute separations. We expect this recommendation leads to greater consistency in contracts between hospitals and insurers.
4	**We recommend that a clearer definition is supplied for the various charge and benefit buckets reported in HCP1.**	Stakeholders have advised that we should not rely on the charge and benefit buckets in HCP1 due to inconsistencies on what is included in each bucket by hospitals and insurers. A clearer definition would allow for a more in-depth analysis of the types and amount of costs charged by hospitals and paid by insurers and therefore, the drivers of any out-of-pocket costs paid by patients.
5	**We recommend that the current data collection processes by hospitals and insurers for HCP1, HCP2 and PHDB are considered when implementing any initiatives for data improvement.**	Stakeholders have commented on the large amount of time and resources required to compile data and align to the data specifications. Stakeholders also noted opportunities to improve training for staff involved in data collection to refine completeness and accuracy of the data supplied.

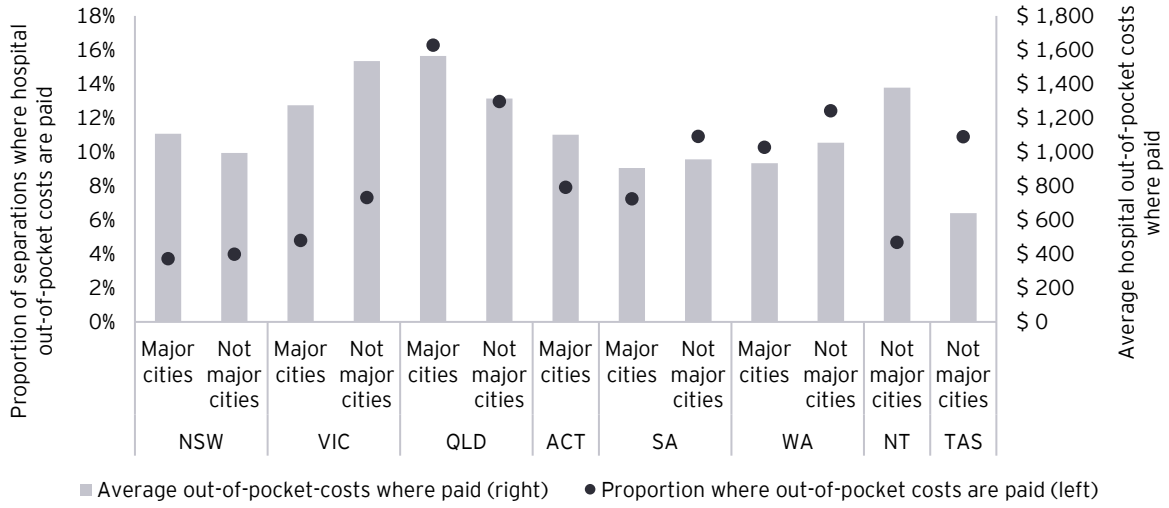
Appendix F Additional analysis

F.1 Out-of-pocket costs

The following Section presents additional analysis to Section 3.2.2 on the out-of-pocket costs paid by patients.

The proportion of separations where hospital out-of-pocket costs are paid and the average hospital out-of-pocket costs for these separations in public hospitals are broken down by jurisdiction in Figure 42. This figure shows that the proportion of separations paying hospital out-of-pocket costs on top of the front-end deductible and the average hospital out-of-pocket costs vary by jurisdiction. However, some jurisdictions have expressed that, if a public hospital offers a no gap guarantee, any difference between the charges and benefits may show up as hospital out-of-pocket costs in HCP1, but are not actually paid by the patient and absorbed by the hospital.

Figure 42: Proportion of privately insured separations in public hospitals that pay hospital out-of-pocket costs and the average hospital out-of-pocket costs for these separations, by state and hospital location



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The hospital location categories were derived from the Modified Monash Model (MMM) categories, where a MM 1 category is major city and MM 2 to 7 were grouped to represent not major cities. Some states do not have both major and non-major city classifications.*
- *The hospital out-of-pocket costs in this analysis are represented as the total hospital charge minus the total hospital benefit minus the front-end deductible for a separation.*
- *This analysis is based on the hospital out-of-pocket costs paid for separations from FY15 to FY20 (inclusive), indexed to 2022-23 using the inflation rates from IHACPA's NEP Determination reports. AA hospital out-of-pocket cost is considered to be paid if it is greater than $1 pre-indexation.*
- *A non-material number of separations where the hospital out-of-pocket costs were less than -$1 was excluded from this analysis.*
- *There has been data cleansing performed on the underlying HCP1 dataset by the Department, which include exclusion of separations where the rounded benefit exceeds the rounded charge by more than $1, and the exclusion of separations where the derived total hospital charge or benefit exceeds $500,000. For detailed exclusions applied, please refer to the explanatory notes within the HCP Annual Report*[69].

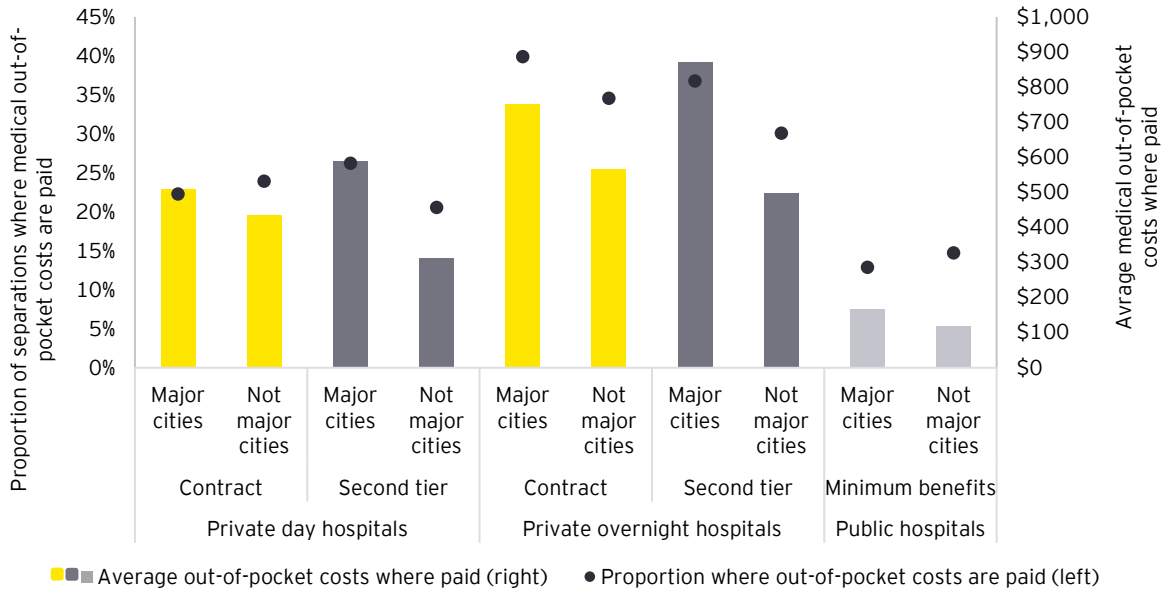
Figure 43 presents the proportion of separations from FY15 to FY20 where the patient paid medical out-of-pocket costs and the average medical out-of-pocket costs for these separations, for each hospital type, contract status and hospital location.

[69] Department of Health and Aged Care. 2021. Hospital Casemix Annual Reports. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

This figure shows that the relationship between medical out-of-pocket costs and the hospital contract status in private hospitals is not conclusive. Generally, the data shows the proportion of separations paying medical out-of-pocket costs is around 5% lower in second-tier funded separations than contracted separations. An exception to this is in private day hospitals in major cities, where the proportion of separations paying medical out-of-pocket costs is around 5% higher in second-tier funded separations. Where medical out-of-pocket costs are paid, the average medical out-of-pocket costs paid is higher in second-tier funded separations in major cities, but lower in non-major cities, when compared to contracted hospitals.

In public hospitals, the proportion of separations paying medical out-of-pocket costs is lower than private hospitals, at around 15%. The average medical out-of-pocket costs where paid is also significantly lower.

Figure 43: Proportion of separations where medical out-of-pocket costs are paid and the average medical out-of-pocket costs for these separations, by contract status, hospital type and hospital location



***Data source: Pre-p**rocessed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The hospital location categories were derived from the Modified Monash Model (MMM) categories, where a MM 1 category is major city and MM 2 to 7 were grouped to represent not major cities.*
- *The identification of hospital type is based on the "Declared information management system hospital type" flag within the HCP1 data. Private overnight hospitals refer to those with a hospital type of "private other".*
- *The medical out-of-pocket costs are represented as the total medical charge minus the total medical benefit for a separation.*
- *This analysis is based on the medical out-of-pocket costs paid for valid separations from FY15 to FY20 (inclusive), indexed to 2022-23 using the inflation rates from IHACPA's NEP Determination reports. An out-of-pocket cost is considered to be paid if it is greater than $1 pre-indexation.*
- *Around 20% of all separations did not have a valid medical record and thus were removed from this analysis to not distort the average medical out-of-pocket costs calculated. However, this may include separations that legitimately did not have a medical record.*
- *There has been data cleansing performed on the underlying HCP1 dataset by the Department of Health and Aged Care, which include exclusion of separations where the rounded benefit exceeds the rounded charge by more than $1, and the exclusion of separations where the derived total hospital charge or benefit exceeds $500,000. For detailed exclusions applied, please refer to the explanatory notes within the HCP Annual Report[70].*

[70] Department of Health and Aged Care. 2021. Hospital Casemix Annual Reports. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

Figure 44 and Figure 45 present the proportion of separations across FY15 to FY20 where the patient paid additional hospital out-of-pocket costs on top of the front-end deductible amount and the average hospital out-of-pocket costs for these separations, by SRG for contracted and second-tier funded separations respectively.

The proportion of separations paying additional hospital out-of-pocket costs and the average hospital out-of-pocket costs where paid varies by SRG for both contracted and second-tier funded separations. Generally, a higher proportion of separations within a SRG pay additional hospital out-of-pocket costs when second-tier funded, compared to contracted. Within contracted and second-tier funded separations, dentistry is the one of the top SRGs with the highest proportion of separations where hospital out-of-pocket costs are paid. Within second-tier funded separations, a significantly higher proportion of gynaecology and palliative care separations pay hospital out-of-pocket costs compared to separations in contracted hospitals.

Figure 44: Proportion of separations where hospital out-of-pocket costs are paid on top of the front-end deductible and the average hospital out-of-pocket costs for these separations, by SRG – Contracted

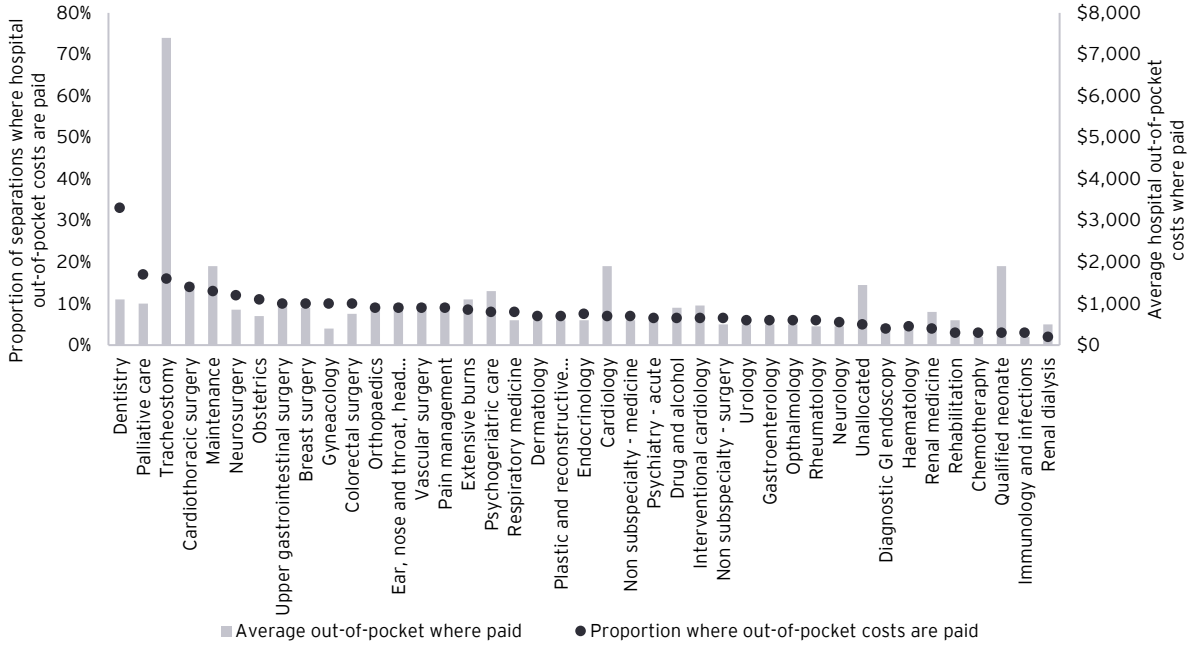
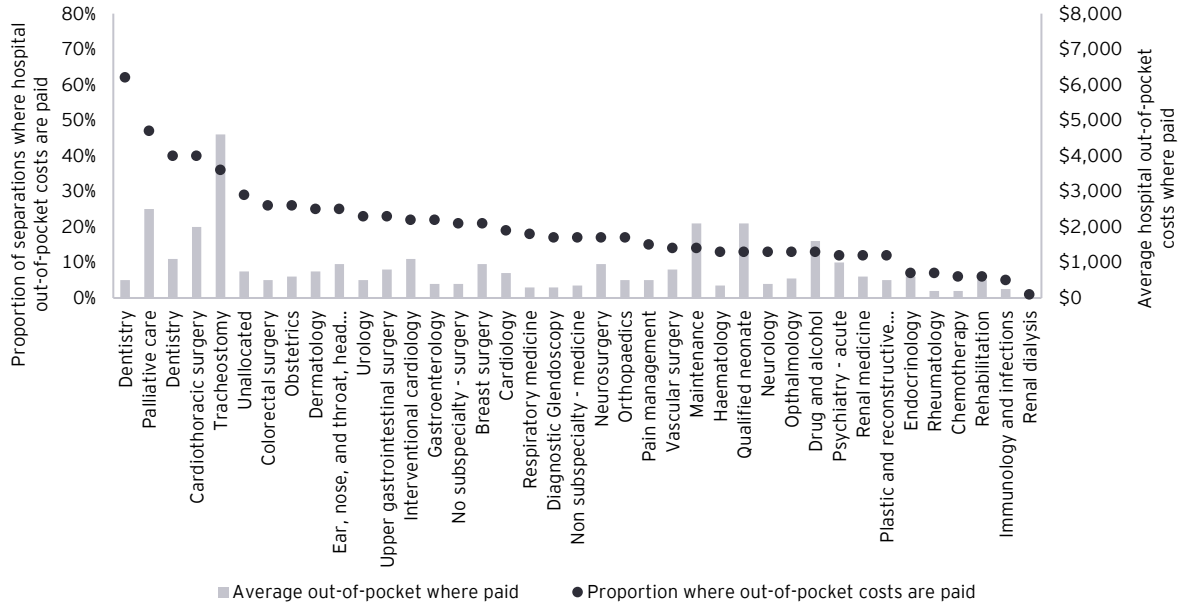


Figure 45: Proportion of separations where hospital out-of-pocket costs are paid on top of the front-end deductible and the average hospital out-of-pocket costs for these separations, by SRG - Second-tier



***Data source**: Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The hospital out-of-pocket costs in this analysis are represented as the total hospital charge minus the total hospital benefit minus the front-end deductible for a separation.*
- *This analysis is based on the hospital out-of-pocket costs paid for separations across FY15 to FY20 (inclusive), indexed to 2022-23 using the inflation rates from IHACPA's NEP Determination reports. AA hospital out-of-pocket cost is considered to be paid if it is greater than $1 pre-indexation.*
- *A non-material number of separations where the hospital out-of-pocket costs were less than -$1 was excluded from this analysis.*
- *In the contracted chart, the transplantation and perinatology SRGs have been removed due to low separation and/or provider counts.*
- *In the second-tier chart, the transplantation, perinatology, psychogeriatric care and extensive burns SRGs have been removed due to low separation and/or provider counts or lack of data.*
- *There has been data cleansing performed on the underlying HCP1 dataset by the Department of Health and Aged Care, which include exclusion of separations where the rounded benefit exceeds the rounded charge by more than $1, and the exclusion of separations where the derived total hospital charge or benefit exceeds $500,000. For detailed exclusions applied, please refer to the explanatory notes within the HCP Annual Report[71].*

Figure 46 and Figure 47 present the proportion of separations from FY15 to FY20 where the patient paid medical out-of-pocket costs and the average medical out-of-pocket costs for these separations, by SRG for contracted and second-tier funded separations, respectively.

As with the hospital out-of-pocket costs, the proportion of separations paying medical out-of-pocket costs and the average medical out-of-pocket costs where paid varies by SRG for both contracted and second-tier funded separations. In particular, 90% of contracted tracheostomy separations pay medical out-of-pocket costs and second-tier funded breast surgery separations pay notably higher medical out-of-pocket costs on average where paid compared to separations in contracted hospitals.

[71] Department of Health and Aged Care. 2021. Hospital Casemix Annual Reports. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

Figure 46: Proportion of separations where medical out-of-pocket costs are paid and the average medical out-of-pocket costs for these separations, by SRG - Contracted

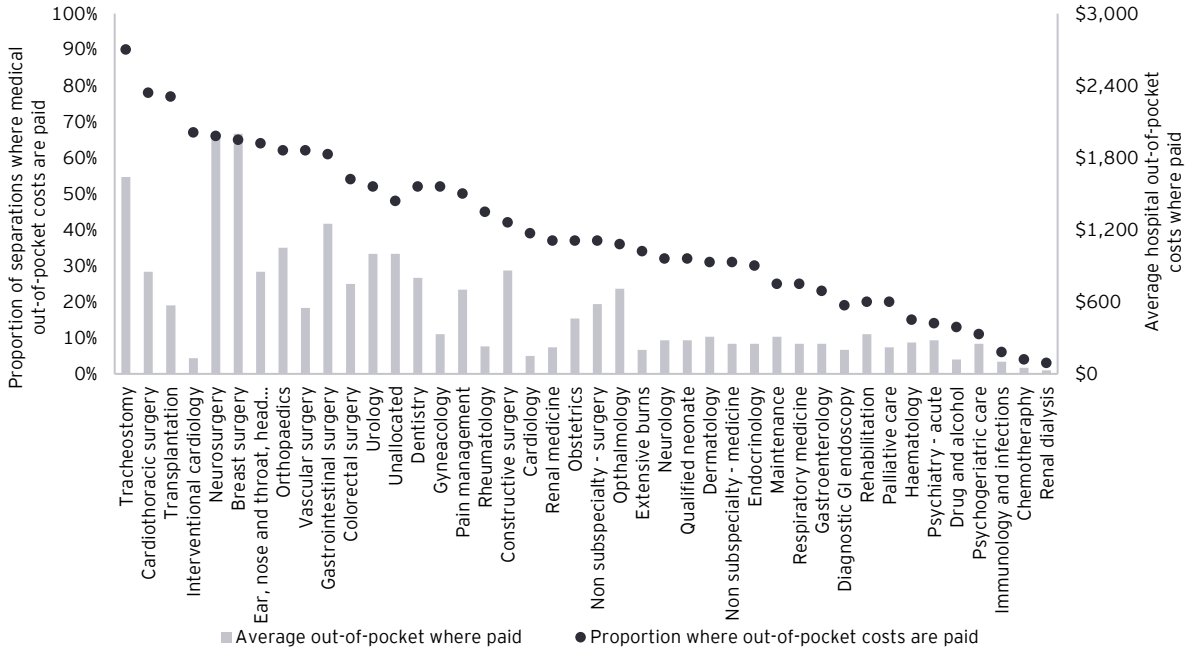
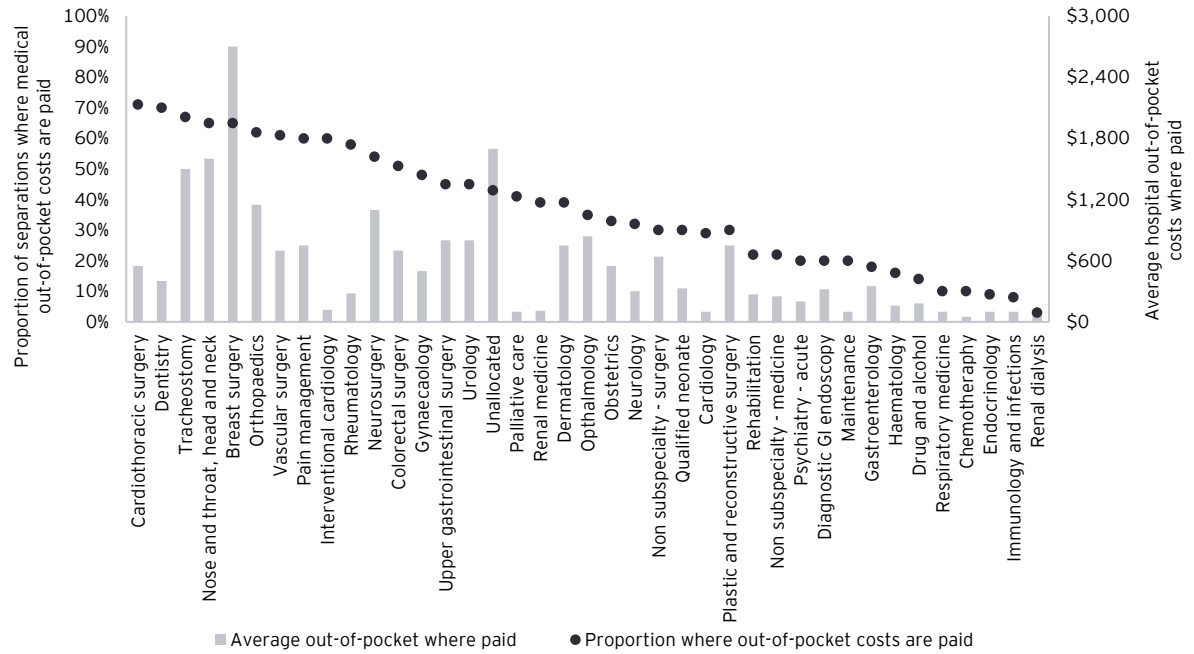


Figure 47: Proportion of separations where medical out-of-pocket costs are paid and the average medical out-of-pocket costs for these separations, by SRG – Second-tier



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *The medical out-of-pocket costs are represented as the total medical charge minus the total medical benefit for a separation.*
- *This analysis is based on the medical out-of-pocket costs paid for valid separations from FY15 to FY20 (inclusive), indexed to 2022-23 using the inflation rates from IHACPA's NEP Determination reports. An out-of-pocket cost is considered to be paid if it is greater than $1 pre-indexation.*
- *Around 20% of all separations did not have a valid medical record and thus were removed from this analysis to not distort the average medical out-of-pocket costs calculated. However, this may include separations that legitimately did not have a medical record.*
- *In the contracted chart, the perinatology SRG has been removed due to low separation and/or provider counts.*

- *In the second-tier chart, the transplantation, perinatology, psychogeriatric care and extensive burns SRGs have been removed due to low separations and/or provider counts or lack of data.*
- *There has been data cleansing performed on the underlying HCP1 dataset by the Department of Health and Aged Care, which include exclusion of separations where the rounded benefit exceeds the rounded charge by more than $1, and the exclusion of separations where the derived total hospital charge or benefit exceeds $500,000. For detailed exclusions applied, please refer to the explanatory notes within the HCP Annual Report.*[72]

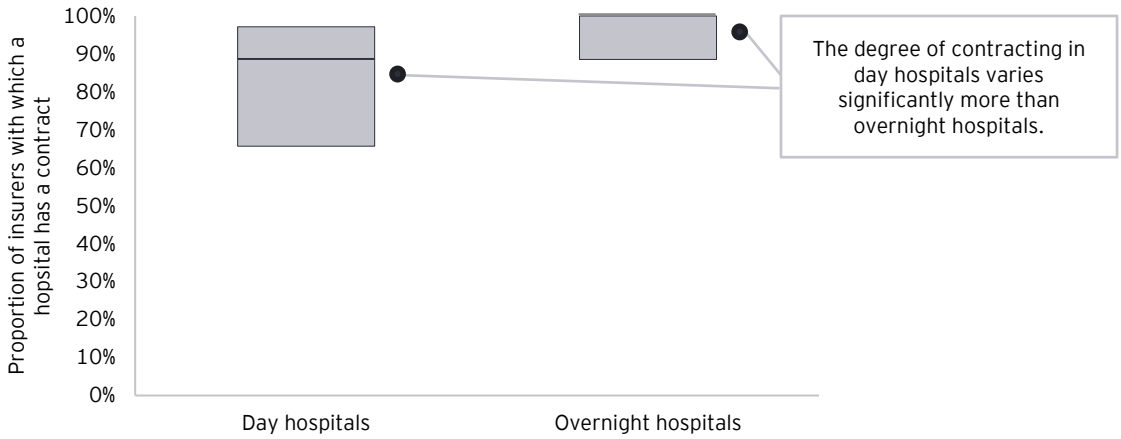
F.2 Contracting by hospital characteristics

The following Section presents additional analysis to Section 3.2.3 on differences in the rate of contracting by a number of hospital characteristics.

By hospital type

Figure 48 presents the use of contracting for day hospitals and overnight hospitals. Day hospitals appear to have more challenges in contracting with insurers.

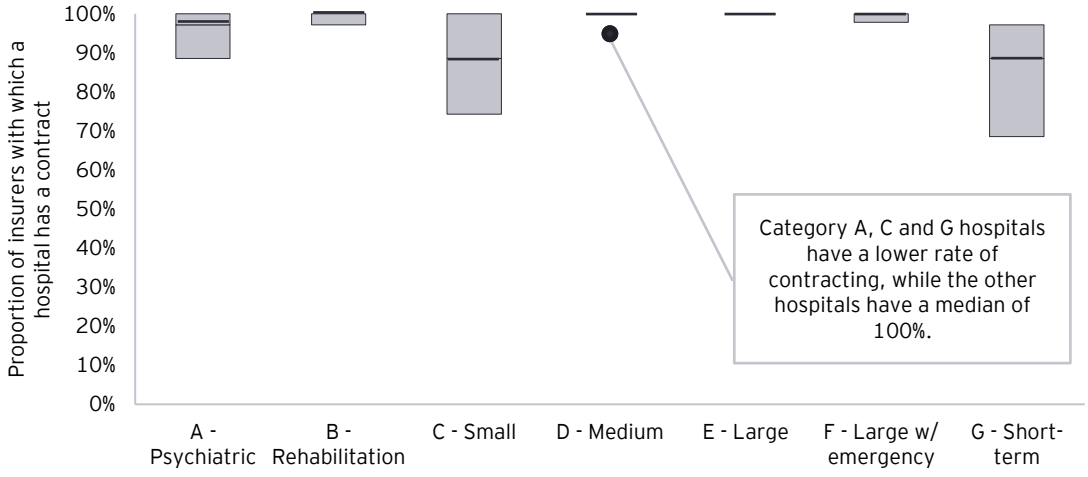
Figure 48: Proportion of insurers with which a hospital has a contract, by hospital type



By hospital category

Figure 49 presents the rate of contracting for each second-tier hospital category. Category A (psychiatric), Category C (small) and Category G (short-term) hospitals have a lower rate of contracting than other categories of hospitals.

Figure 49: Proportion of insurers with which a hospital has a contract, by hospital category

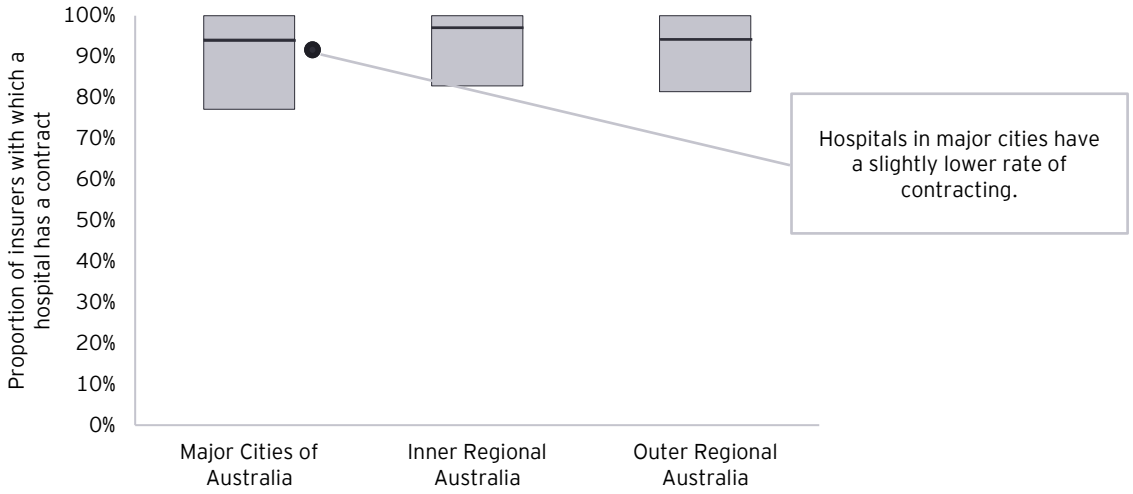


[72] Department of Health and Aged Care. 2021. Hospital Casemix Annual Reports. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

By remoteness area

Figure 50 presents the use of contracting for hospitals by remoteness area. The degree of contracting does not vary significantly between major cities and regional Australia.

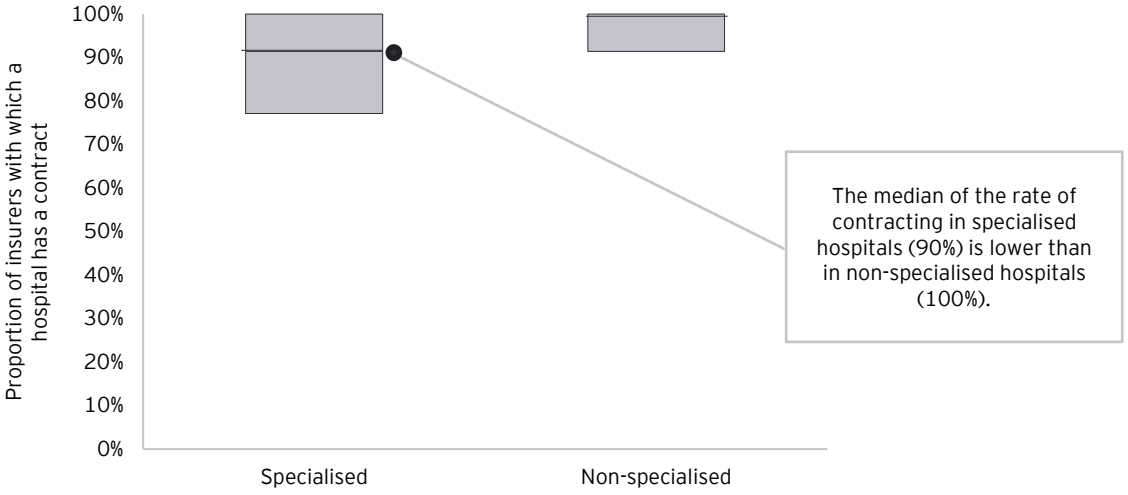
Figure 50: Proportion of insurers with which a hospital has a contract, by hospital remoteness area



By specialisation

Figure 51 compares the use of contracting between specialised hospitals and non-specialised hospitals. A hospital was defined as specialised where a majority of its separations were under a single SRG in FY21. Specialised facilities show evidence of a lower rate of contracts with insurers.

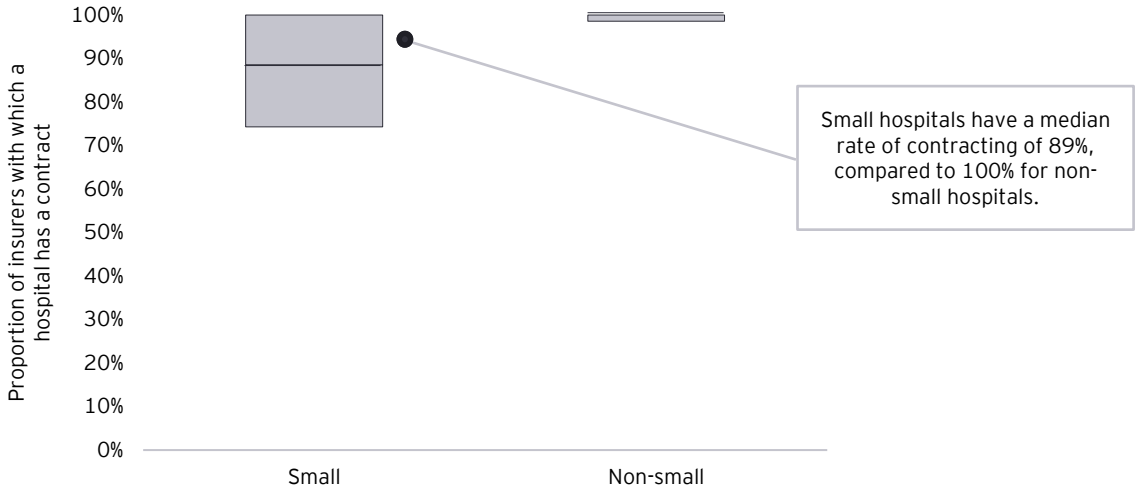
Figure 51: Proportion of insurers with which a hospital has a contract, by hospital specialisation



By hospital size

Figure 52 compares the use of contracting between small and non-small hospitals. A hospital is defined as small if it has reported less than or equal to 50 beds. Small hospitals have contracts with a lower proportion of insurers than other hospitals.

Figure 52: Proportion of insurers with which a hospital has a contract, by hospital size



Data source: *Data.gov.au Agreement Hospitals matrix 1 August 2022, Hospital data held by the Department, Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022), Private hospital second-tier category lists*

Interpretation, limits and cautions:

- *The boxplot presents the distribution of the proportion of insurers that a hospital is contracted with as at 1 August 2022 for different hospital characteristics. For a given hospital, this is calculated by the following:*

$$\text{Proportion of insurers that a hospital is contracted with} = \frac{\text{Number of insurers indicated as having a contract}}{\text{Total number of insurers in Agreement Hospitals matrix}}$$

- *The box represents the range between the 1st quartile and 3rd quartile of percentages, i.e., 50% of hospitals lie in this box.*
- *Outputs are sensitive to the underlying data and our definitions of the hospital characteristics. For each characteristic, hospitals that are missing the relevant data were excluded from the analysis. Data quality issues may impact the distributions shown.*
- *A smaller number of hospitals may result in a seemingly larger range between the 1st and 3rd quartile, purely due to the smaller number of observations with a large range. However, a large range in values may be an indication of the need of a safety net.*

F.3 Procedures with unwarranted variation

The following Section refers to four treatments of interest from the 2021 ACSQHC Atlas of Variation[73]. The ACSQHC's works to identify potentially unwarranted variation in healthcare items and procedures and reveals signs that suggest sub-optimal healthcare delivery. The aim of our analysis was to identify whether there is a difference in rates of these procedures for separations funded under default benefits compared to funded under contractual arrangements.

Tonsillectomy[74] - The Atlas of Variation states this is a common surgery in childhood that is used to treat recurrent throat infections that affect the tonsils (tonsillitis) and obstructive sleep apnoea (OSA), but there are uncertainties about its benefits. The Atlas of Variation states that it is not clear if children with these conditions always benefit from surgery, or whether they would get better without surgery. The ACSQHC quotes 42,509 hospitalisations in 2017-18, where 60% (25,505) of these were for privately funded separations.

[73] Australian Commission on Safety and Quality in Health Care. 2021. The Fourth Australian Atlas of Healthcare Variation. Available at: www.safetyandquality.gov.au/sites/default/files/2021-04/The%20Fourth%20Australian%20Atlas%20of%20Healthcare%20Variation%202021_Full%20publication.pdf

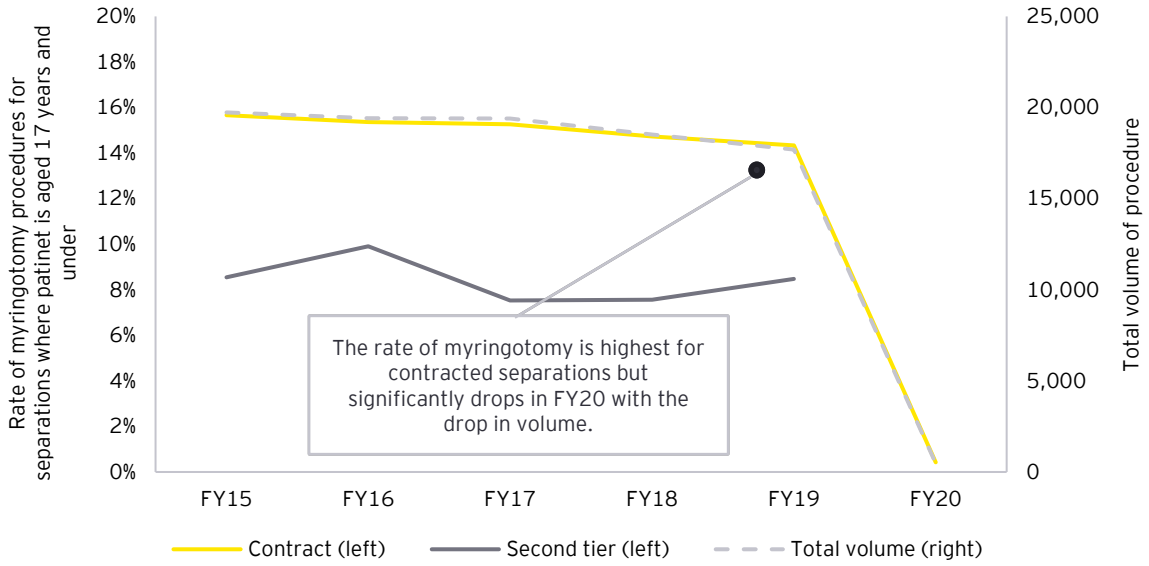
[74] Separations with tonsillectomy procedures were identified using the data specifications within Number of tonsillectomy hospitalisations per 100,000 people aged 17 years and under, 2012-13, 2015-16 and 2017-18 (www.meteor.aihw.gov.au/content/723655).

Figure 27 (page 46) shows the volume of tonsillectomy hospitalisations in private hospitals and the rate of occurrence by contract status, based on the total number of separations where the patient is 17 years and under. The rate of occurrence was highest in contracted separations, remaining stable at around 16%, compared to a rate of 8% to 12% for second-tier funded separations across all years.

Myringotomy[75] - The Atlas of Variation states this is one of the most common surgeries done in young children. It is used to treat middle ear infections (otitis media), which can cause hearing loss. The Atlas states that most children with otitis media do not require surgery and watchful waiting is recommended, but in some cases, myringotomy with grommets is the most effective option. The ACSQHC quotes 34,755 hospitalisations in 2017-18, where 60% (20,853) of these were for privately funded separations.

Figure 53 shows the volume of myringotomy hospitalisations in private hospitals and the rate of occurrence by contract status, based on the total number of separations where the patient is 17 years and under. The total volume has significantly dropped from around 18,000 separations in FY19 to around 500 separations in FY20. Whilst some of this impact can be explained by the pausing of ear, nose and throat surgeries during the last quarter of FY20 due to COVID-19, there may be another factor that drives the low volumes in FY20. Generally, contracted separations have a higher occurrence of myringotomy procedures for separations in contracted hospitals compared to separations in second-tier funded hospitals, until the drop in FY20.

Figure 53: Rate and volume of myringotomy hospitalisations for patients 17 years and under



Data source: *Pre-processed HCP1 data and accompanying procedure data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

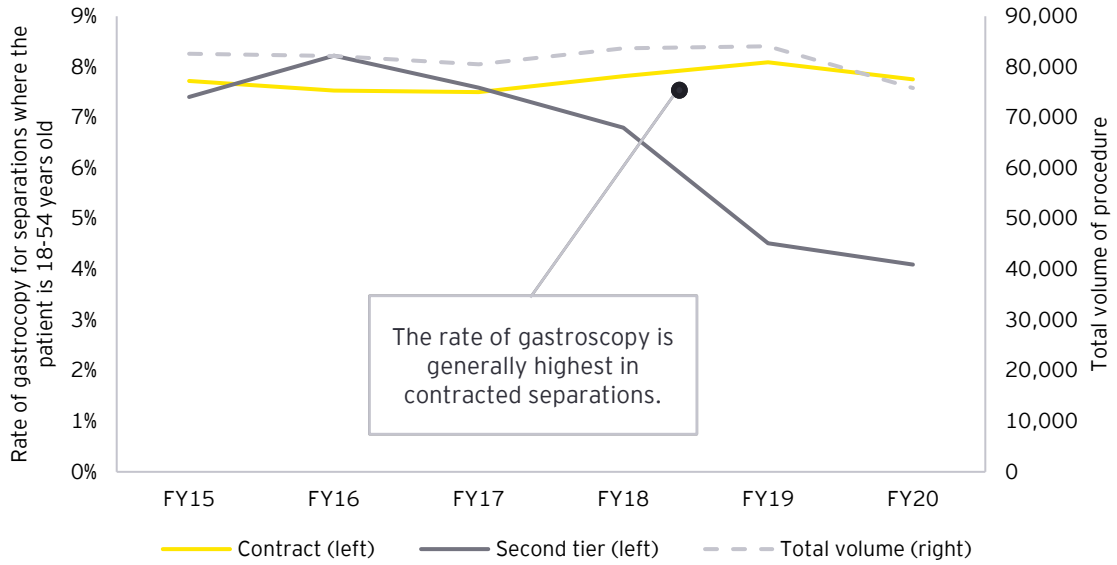
- *A myringotomy hospitalisation was identified using the procedure data accompanying HCP1. Only separations where the accompanying procedure data is available were included in this analysis.*
- *This chart only includes private hospitals separations due to the lower quality of procedure data for public hospital separations.*
- *The data for not contracted and second-tier separations in FY20 has been removed due to low separations and/or provider counts.*
- *The rate of myringotomy procedures is calculated as, where the patient is 17 years and under, the number of separations with a myringotomy procedure divided by the total number of separations.*

[75] Separations with myringotomy procedures were identified using the data specifications within Number of myringotomy hospitalisations per 100,000 people aged 17 years and under, 2012-13, 2015-16 and 2017-18 (www.meteor.aihw.gov.au/content/725734).

Gastroscopy[76] - The Atlas of Variation states this is used to investigate, treat or monitor conditions of the upper part of the gastrointestinal (GI) tract. The Atlas of Variation states that most conditions that affect the upper GI tract and require gastroscopy are uncommon in people aged under 55 years. The ACSQHC quoted 154,338 MBS-subsidised services for gastroscopy in 2018-19. This volume is for all MBS services, regardless of setting, and may include services in non-admitted MBS clinics.

Figure 54 shows the volume of gastroscopy services in private hospitals and the rate of occurrence by contract status, based on the total number of separations where the patient is 18-54 years old. The total volume has been relatively stable at around 80,000 services per financial year. The rate of occurrence is generally highest in contracted separations at around 8% and has decreased over time for second-tier funded separations from around 8% in FY16 to around 4% in FY20.

Figure 54: Rate and volume of gastroscopy services where the patient is 18-54 years



Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *A gastroscopy service was identified using the primary and secondary MBS items reported in HCP1. Only separations with the relevant MBS item and a valid medical record was identified as a gastroscopy services.*
- *This chart only includes private hospitals separations due to the lower quality of MBS data for public hospital separations.*
- *The data for not contracted and second-tier separations in FY20 has been removed due to low separations and/or provider counts.*
- *The rate of gastroscopy procedures is calculated as, where the patient is 18-54 years old, the number of separations with a gastroscopy procedure divided by the total number of separations.*

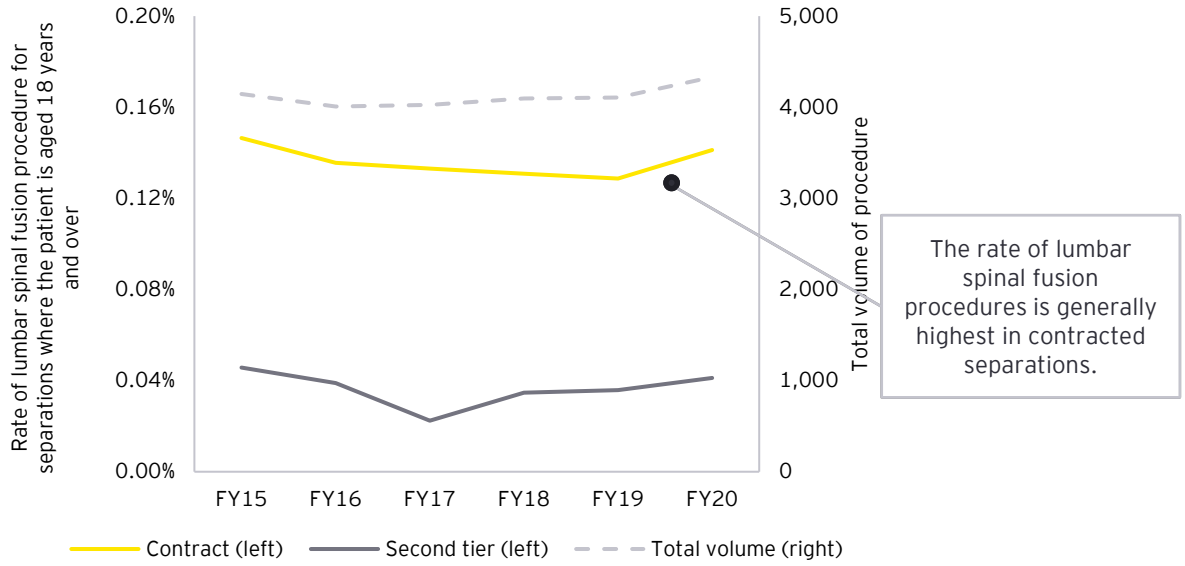
Lumbar spinal fusion[77] - The Atlas of Variation states this surgery has a role in treating a small number of people who have degenerative spinal disorders with nerve-related problems. The Atlas of Variation states that the role of spinal fusion in people without these problems is limited and controversial. ASQHC quoted an estimate (on average) of 4,800 hospitalisations for lumbar spinal fusion in each year between FY16 and FY18, where 83% (approximately 4,000) of these were for privately funded patients.

[76] Separations with gastroscopy separations were identified using the data specifications within Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18-54 years, 2018-19. (www.meteor.aihw.gov.au/content/726343)

[77] Separations with lumbar spinal fusion procedures were identified using the data specifications within Number of lumbar spinal fusion (with or without lumbar spinal decompression) hospitalisations per 100,000 people, aged 18 years and over, 2012-13 to 2014-15 and 2015-16 to 2017-18. (www.meteor.aihw.gov.au/content/724443)

Figure 55 shows the volume of lumbar spinal fusion hospitalisations in private hospitals and the rate of occurrence by contract status, based on the total number of separations where the patient is 18 years and over. The total volume has been quite low and relatively stable at just above 4,000 hospitalisations each year. The rate of occurrence is higher in contracted separations at around 0.15% each year, compared to second-tier funded separations.

Figure 55: Rate and volume of lumbar spinal fusion procedures where the patient is 18 years and over



***Data source**: Pre-processed HCP1 data and accompanying procedure and diagnosis data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *A lumbar spinal fusion hospitalisation was identified using the procedure and diagnosis data accompanying HCP1. Only separations where the accompanying procedure and diagnosis data is available were included in this analysis.*
- *This chart only includes private hospitals separations due to the lower quality of procedure data for public hospital separations.*
- *The rate of lumbar spinal fusion procedures is calculated as, where the patient is 18 years and over, the number of separations with a lumbar spinal fusion procedure divided by the total number of separations.*

F.4 Application of public NEP model

We conducted analysis on an indicative comparison of:

- Private patient funding from current arrangements of contracting and default benefits.
- Public patient funding through IHACPA current NEP model (NWAU(22)).

This analysis estimates the separation-level funding impacts if the funding amounts under the IHACPA model for public patients is applied to fund privately insured patients.

There are a number of considerations when interpreting the indicative analysis:

- The results of this analysis should not be interpreted as calculating the gains or losses for each hospital in shifting to a model similar to the NEP model. The main purposes of the NEP model are to determine the amount of Commonwealth Government funding for public hospital services, and to provide a price signal or benchmark about the efficient cost of providing public hospital services.[78] This analysis does not factor the application of state-based funding models that determine the amount of funding that public hospitals receive.

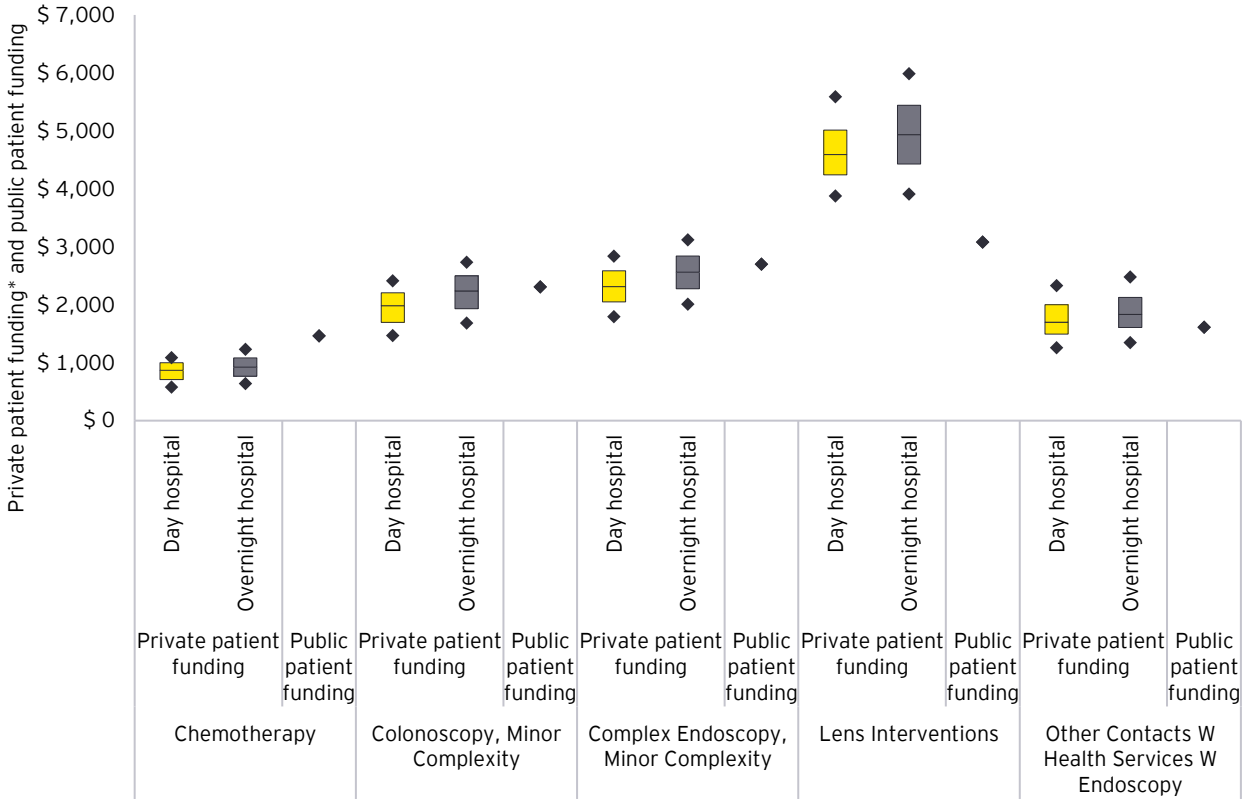
- This analysis provides an indicative view if the IHACPA NEP Model were used in its current form. If an independently set funding model is under consideration as a reform opportunity for determining default benefits, a model will need to be developed that is appropriate for the services provided, costs incurred and interactions in the private health system.

- The funding for private patients takes into account all funding sources (insurer benefits, Medicare benefits, and out-of-pocket costs) for hospital and medical benefits in private hospitals only.

Figure 56 compares the total private patient funding for private hospitals reported in HCP1 and the public patient funding calculated for each separation using the NEP model, for the 5 most frequent AR-DRGs for same-day separations. These 5 DRGs make up 42% of all private hospital same-day separations.

For each of these AR-DRGs, 80% of separations would receive the same funding under the NEP model compared to the wide range of funding amounts reported in HCP1.

Figure 56: Private patient funding in private hospitals and equivalent public patient funding according to NWAU(22), for the 5 most frequent AR-DRGs for same-day separations



** indexed to 2022-23 using inflation rates noted in NEP Determination reports*

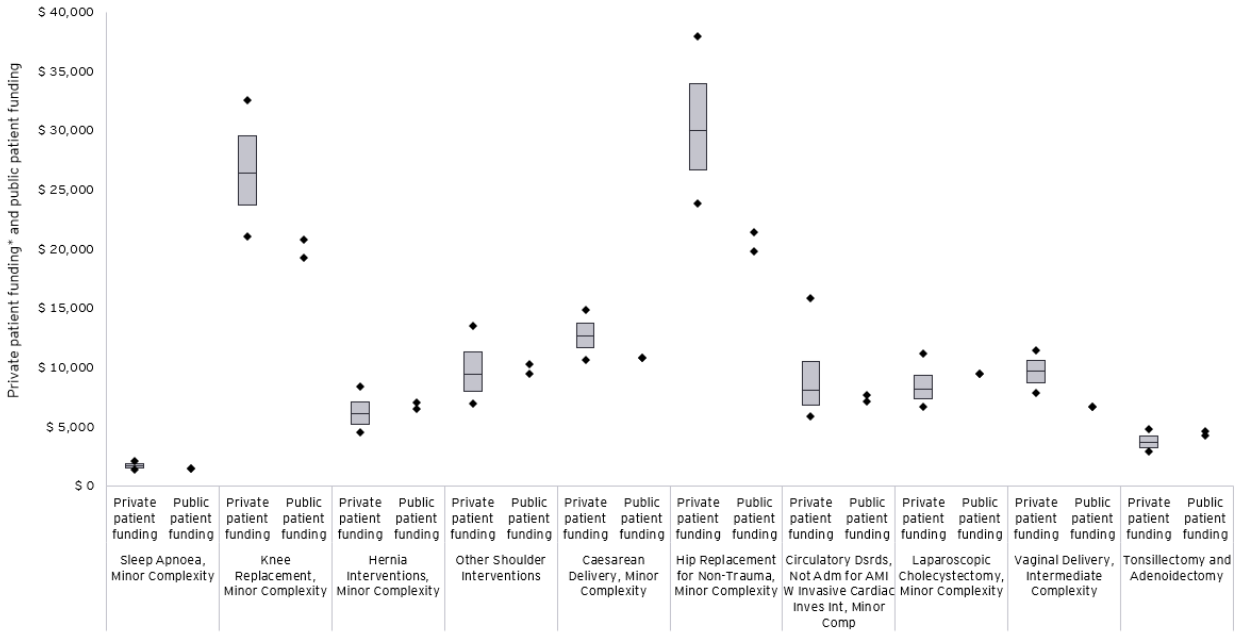
Refer to the accompanying text in Figure 57 for details on the data source and interpretation, limits and cautions.

[78] Independent Health and Aged Care Pricing Authority. 2022. National Efficient Price Determination. Available at: www.ihacpa.gov.au/health-care/pricing/national-efficient-price-determination

Figure 57 compares the total private patient funding for private hospitals and public patient funding calculated for each separation for the 10 most frequent AR-DRGs for overnight separations. These 10 AR-DRGs make up 21% of all private hospital overnight separations. Some variability in the funding received for these separations can be attributed to the distribution in the length of stay.

For each of these AR-DRGs, the funding either convenes to a single point for 80% of separations or has a significantly smaller range between the 10th and 90th percentile.

Figure 57: Private patient funding in private hospitals and equivalent public patient funding according to NWAU23, for the 10 most frequent AR-DRGs for overnight separations



** indexed to 2022-23 using inflation rates noted in NEP Determination reports*

Data source: *Pre-processed HCP1 data supplied by the Department (extracted 14 Sep 2022)*

Interpretation, limits and cautions:

- *Represents the distribution of total funding received for a private patient separation reported in HCP1 and the total funding that would be received for that separation in the public system as calculated by IHACPA's NEP model.*
- *The figure is an adapted box-and-whisker chart, showing the 10th, 25th, 50th, 75th and 90th percentile.*
- *The figure includes all admitted acute care separations with a valid medical record in private hospitals from FY15 to FY20 (inclusive), with benefit amounts from HCP1 indexed to 2022-23 using inflation rates noted in NEP Determination reports.*
- *This chart uses AR-DRG version 10.0. Where version 10.0 AR-DRGs were not available, mapping assumptions were made using available versions of AR-DRG. The results are sensitive to the mapping assumptions used.*
- *In determining the public patient funding using the NEP model, relevant adjustments were applied based on available data. Some adjustments were not applied where information to determine whether the separation was eligible for the adjustments was not available. Adjustments not applied include the Indigenous adjustment, hospital acquired complication adjustment and avoidable hospital readmission adjustment.*

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ED None

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