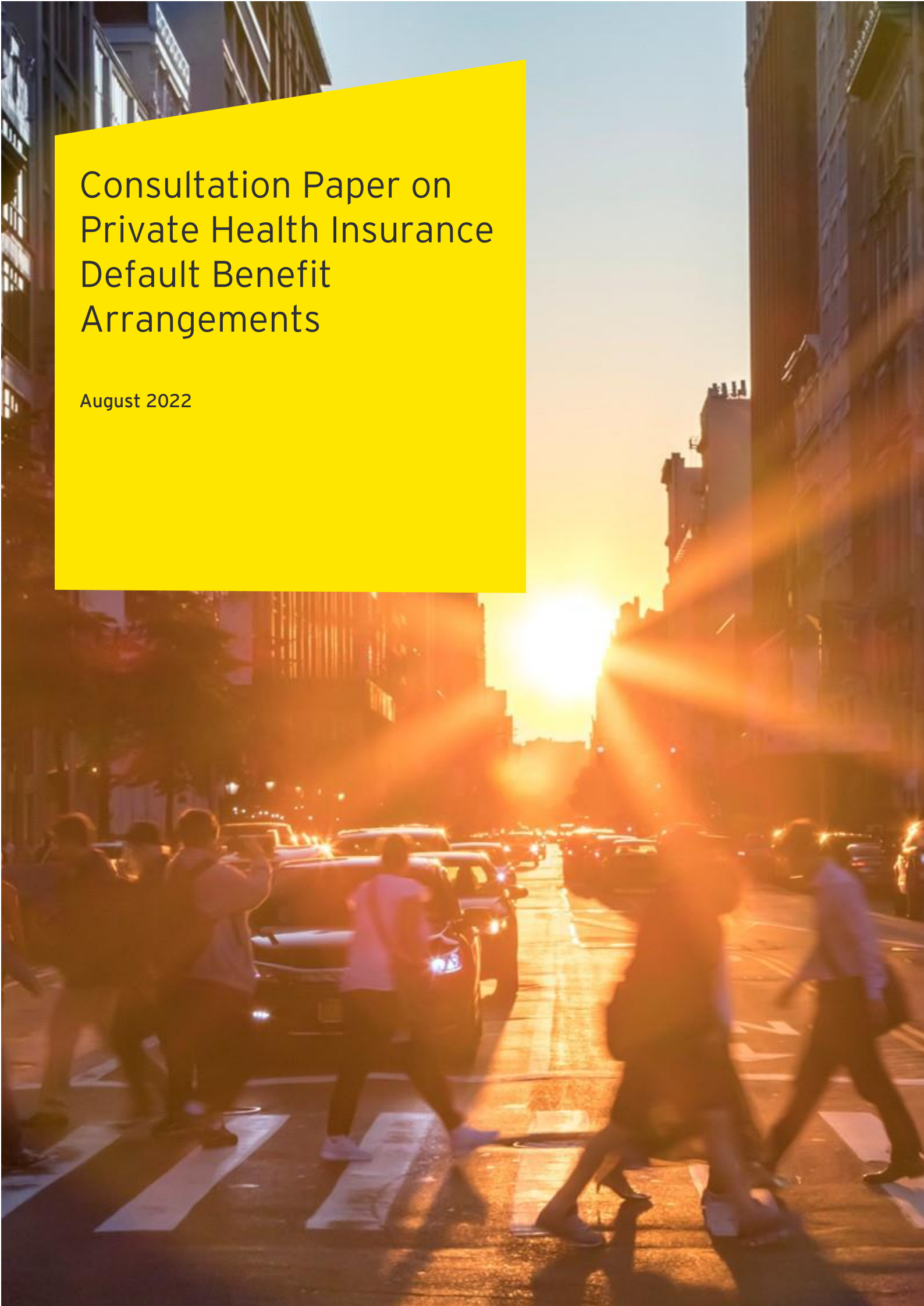
Consultation Paper on Private Health Insurance Default Benefit Arrangements

August 2022



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This consultation paper describes EY's perspectives on the current funding arrangements between private hospitals and private health insurers, their implications and some potential reform options. We are seeking views and supporting information from interested stakeholders in relation to these.

1. Background

1.1 Private health insurance reform and default benefit arrangements

Between 2007 and 2021, private health insurance (PHI) premiums increased by an average of 4.9%[1] per year, while the Average Weekly Earnings (AWE) index increased by 3.0%[2] annually. With an ageing population and improved health technology, Private Health Insurance (PHI) claims costs are expected to continue to increase faster than increases in the Consumer Price Index (CPI) and AWE over the next 10 years.

In October 2017, the Australian Government announced regulatory reforms supporting premium affordability. In the 2020-21 Budget, the Government announced it would work with private health insurers, hospitals, and health care providers to develop and implement further reforms to support greater uptake of PHI, including through affordable premiums and improving the value proposition of PHI. In doing so, the Department of Health and Aged Care (the Department) is conducting studies into the effectiveness of some key policy mechanisms intended to support the sustainability of PHI.

PHI default benefit arrangements are one of these policy mechanisms. They are long-standing regulatory arrangements that have been in place for nearly 30 years. The precise intent of these arrangements is the subject of some debate among stakeholders, at a high-level, they aim to improve the access to and choice of private healthcare services for consumers and, in doing so, support the value proposition of PHI and private hospitals.

The arrangements introduce two 'tiers' of default benefits, **minimum benefits** and **second-tier default benefits**, payable from private health insurers to certain hospitals in situations where there is no privately-agreed contract between the parties.

Minimum benefits are the minimum amount an insurer is required to pay for a hospital admission covered on a consumer's PHI policy[3]. The minimum amount is set by the Australian Government and is outlined in the *Private Health Insurance (Benefit Requirements) Rules 2011*. The minimum amount may vary depending on services provided and is discussed in Section 2.2.2.1

Second-tier default benefits are only available to eligible private hospitals and are calculated as no less than 85% of the average charge of the equivalent episode of hospital treatment under the insurer's contracts with similar facilities in that state or territory as outlined in the *Private Health Insurance (Benefit Requirements) Rules 2011*. Second-tier default benefits are discussed in Section 2.2.2.2

Multiple government agencies have essential roles in supporting an integrated healthcare system which puts the patient at its centre. In doing so, many of their roles and responsibilities directly interact with PHI default benefit arrangements. The Department directly oversees the minimum and second-tier default benefits. State and Territory governments oversee the licensing of hospitals and ensure the relevant accreditation requirements are implemented, in support of the Australian

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

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

[3] Private health.gov.au. Glossary. Available from https://www.privatehealth.gov.au/footer/glossary.htm

Commission on Safety and Quality in Health Care (ACSQHC), which defines these accreditation requirements nationally. The PHI benefits are provided for under the *Private Health Insurance Act 2007* (the PHI Act), and specifically under the *Private Health Insurance (Benefit Requirements) Rules 2011* (the PHI benefits requirements rules).

1.2 Purpose of this study

The purpose of this study is to identify reform opportunities for PHI default benefit arrangements with a view to better supporting the provision of high-value healthcare and outcomes for consumers. This will support improvements in accessibility and efficiency of privately insured hospital services in the market.

Ernst & Young (EY) has been contracted by the Department to undertake an independent study (this study) of PHI default benefit arrangements. The Department intends to use the findings of this study in conjunction with the progress of the Prostheses List (PL) reforms and findings of actuarial studies of Lifetime Health Cover (LHC) and Risk Equalisation (RE), and the Medicare Levy Surcharge (MLS) and PHI Rebate, to consider broader reform options for the regulatory settings for the PHI sector. There is a central focus on improving the patient experience and health outcomes by supporting consumer healthcare and utilising Australia's strong healthcare system foundation.

A multi-faceted approach has been designed to enable a comprehensive, robust, and dynamic investigation into the hospital default benefit funding arrangements. Our approach involves reviewing the current arrangements and potential options for reform through a combination of stakeholder consultation, qualitative analysis and quantitative analysis.

1.3 Purpose of this consultation paper

The purpose of this consultation paper is to seek your response and any supporting data, evidence and information on:

1. The current state of minimum and second-tier default benefits
2. The impact of the default benefits on the assessment criteria for this study *(discussed in Section 3)*; and
3. Potential future options (*discussed in Section 4*), including considerations relating to implementation of any changes and timeframes for implementation.

There will be further opportunities to consider implementation issues in more detail as reform options are developed.

Your feedback will inform EY's report and provide support to the Department's considerations for further PHI reform.

1.4 How to interpret this consultation paper

Some preliminary study findings to date are presented in this Consultation Paper. They have been informed by targeted individual stakeholder consultations, workshops with private day hospitals, private hospitals and private health insurers. A full list of the consultation questions can be found in Appendix A.

The questions in this Consultation Paper are intended to prompt your views and responses on the current arrangements and potential options for change. Questions that are prefaced with '*Option*

for Change' are intended for your consideration of what reform could look like. These questions are there to seek specific information to guide the options development. The current options are detailed in Section 4.

1.5 How to submit your responses

The preferred means of response is by email to phidefaultbenefits@au.ey.com. Please provide your input and supporting evidence, for those questions you wish to answer, as well as any additional information or comments, such as data information and potential future option models.

Email submissions will receive an acknowledgement of receipt within 5 working days. EY may choose to invite respondents to meet to discuss issues raised in more detail.

Please note that EY will share your responses with the Department of Health and Aged Care and may refer to your responses in our report(s) to the Department. Neither you nor your organisation will be identified in any reports or correspondence with any other third parties. Please highlight any aspects of your response which are commercially sensitive and not to be included in our report(s) to the Department.

Submissions will be accepted up to 23 September 2022. For any questions, please do not hesitate to send an email to phidefaultbenefits@au.ey.com.

Thank you in advance for your time and participation.

This consultation paper is the key opportunity to provide your point of view, with supporting evidence, to inform this independent study, and your contributions are welcomed and encouraged.

When responding please indicate whether you are contributing to the consultation process as a healthcare adviser, healthcare provider, representative body, business representative, member of the public, or in any other capacity. Submissions from consumers and consumer groups are encouraged.

Please ensure you itemise your responses by using the corresponding question number in the consultation paper.

If you have additional information or comments regarding the study that are not covered by the questions in this consultation paper, or if you wish to provide general commentary on the issues covered in this consultation paper, please include this in your email response.

2. Overview of private health insurance

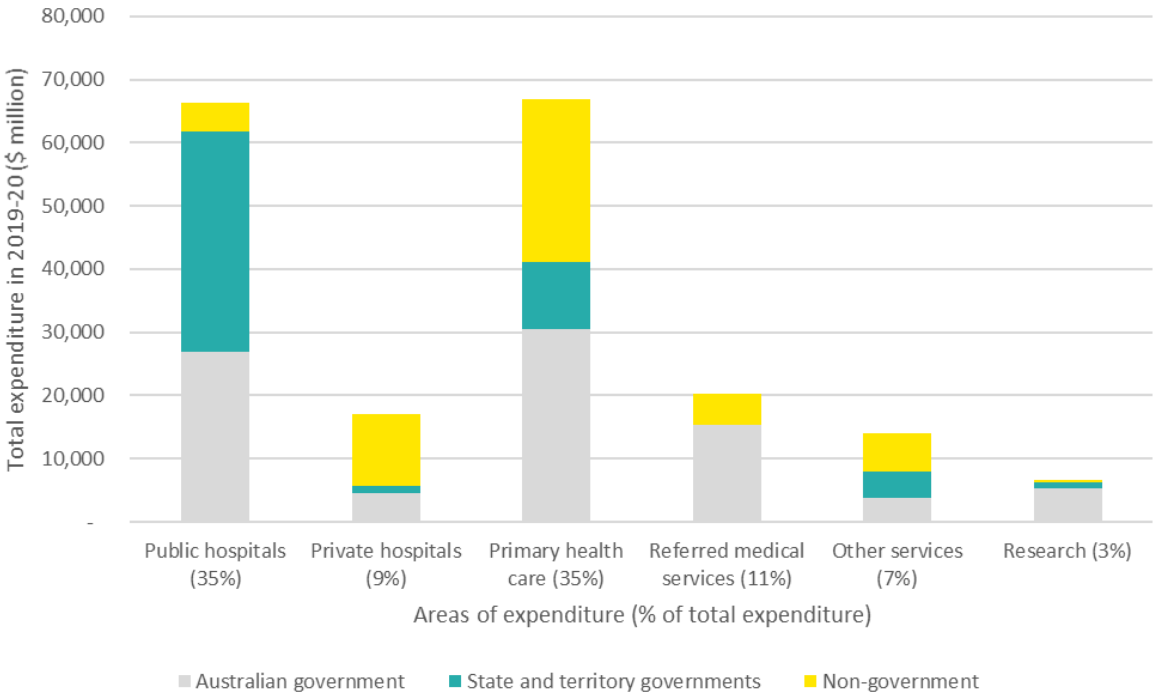
This section provides an overview of the role private health insurance plays in the Australian healthcare system and outlines the current PHI funding arrangements.

2.1 The role of private health insurance in the Australian 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, governments, and individual (out-of-pocket) contributions.[4] According to research conducted by Private Healthcare Australia, approximately 65% of the population believes the quality of the health system in their state or territory is very high,[5] suggesting this mixed public/private health system is highly regarded by the Australian community.

The Australian healthcare system is composed of various public and private funders and providers. Figure 1 summarises the relative size of expenditure in hospitals, primary healthcare and other services, the split of responsibilities for the provision of services within each sector, and the sources of funding for each of these services.

Figure 1: Area of spending by source of funds, FY20



Source: Australian Institute of Health and Welfare 2022[6]

Through Medicare, the PHI Rebate and the Commonwealth/State health funding agreements, the Australian government is the main funder for consumers accessing healthcare services. Medicare includes the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and

[4] Australian Institute of Health and Welfare, 2022, Hospitals at a glance

[5] Private Healthcare Australia. 2017-2018. Ideas for improving the value and affordability of private health insurance. Available at: https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Private-Healthcare-Australia-Budget-Submission-2017-18.pdf

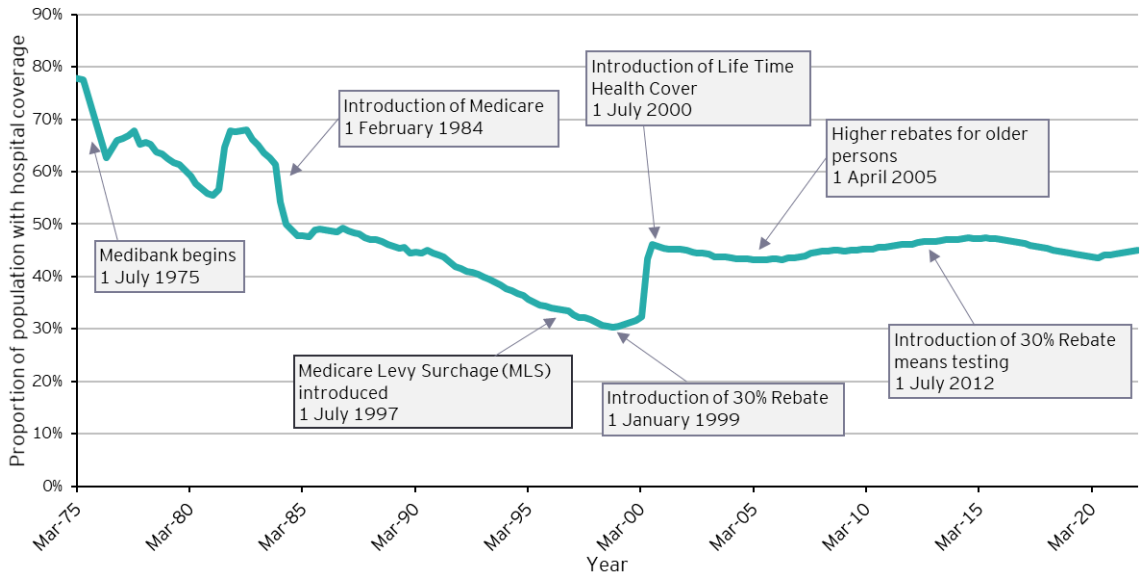
[6] Australian Institute of Health and Welfare, 2022. Health expenditure. Available at https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure

public hospitals. More information about the PHI rebate is at www.privatehealth.gov.au/health_insurance/surcharges_incentives/insurance_rebate.htm.

The private sector 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) fund specialist treatments associated with hospital accommodation costs. This does not include funding costs relating to GP referral, consultations, and assessments with specialists prior to treatment. In the private sector, medications, and medical services (referred and non-referred) are also predominantly funded through the MBS and PBS.

PHI is a key part of the healthcare system in Australia. It provides millions of Australians with choice and access to private healthcare services, particularly planned, elective, and non-emergency services. Approximately 45% of Australians hold PHI hospital cover, as shown in Figure 2. Compared to public hospitals, private hospitals deliver a higher proportion of admitted elective surgery services but much smaller proportions of outpatient and emergency services. Waiting times for elective surgeries tend to be shorter in the private healthcare system. Health services provided in private hospitals are typically attractive to patients as like-for-like services tend to have shorter waiting times than in the public system.

Figure 2: Proportion of the Australian population with a private health insurance hospital product



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

2.2 Current funding arrangements between hospitals and private health insurers

The hospital component for services provided in a hospital setting, including accommodation and theatre fees, are funded by private health insurers via:

- Contractual arrangements between a private hospital and private health insurer, or
- Regulated default benefit arrangements (minimum or second-tier).

These are explored in more detail below.

Note that private health insurers also contribute towards the medical charge for services performed in hospitals through separate contractual arrangements with the medical specialists. These medical charges are partially funded through the Medical Benefits Schedule (MBS).

Both the hospital and medical components of the total cost can attract separate out-of-pocket expenses for PHI consumers.

2.2.1 Contractual arrangements

Contracts between private health insurers and private hospitals define the benefits that insurers will pay for health care services delivered to their members and the non-price conditions that hospitals must meet to receive those benefits.

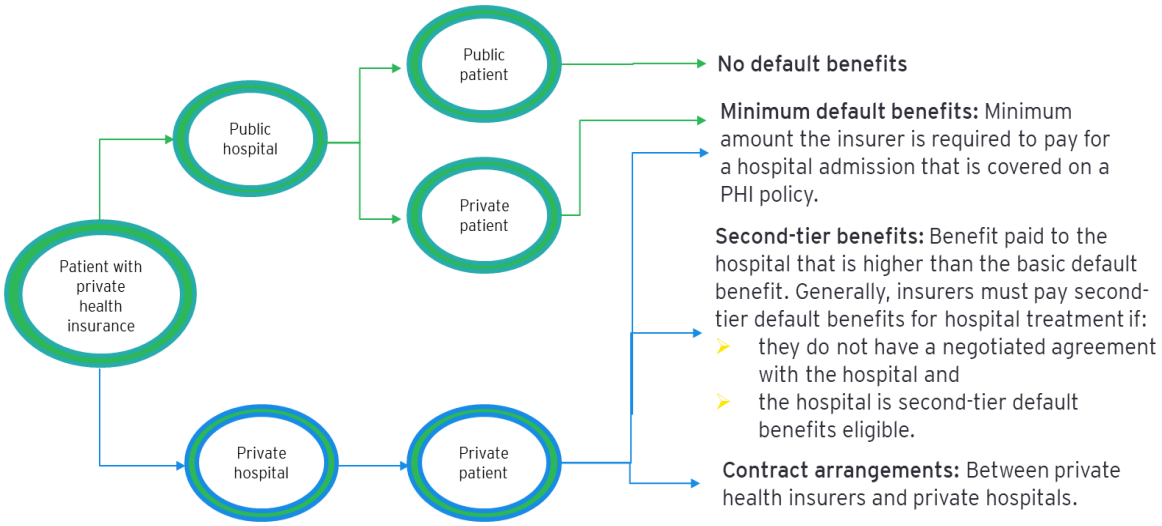
Contractual arrangements provide an opportunity for private health insurers and private hospitals to establish a mutually agreeable arrangement. Private hospitals and private health insurers generally agree that contractual arrangements are the preferred type of funding arrangement. Consumers can generally expect lower out-of-pockets under contractual arrangements, all else being equal. However, contractual agreements are not always achieved. This may occur due to imbalances in the negotiations process, asymmetry of information, and disagreement on maintaining contractual funding rates within industry benchmarks. Failure to achieve contracts may lead to higher out-of-pocket costs for PHI consumers, and reduce the perceived value of PHI for consumers.

2.2.2 Private health insurance default benefit arrangements

Minimum and second-tier default benefits (together, 'default benefit arrangements') are defined by Commonwealth legislation and support PHI consumers by guaranteeing some level of reimbursement for private healthcare services received in private hospitals that do not have a contract with the consumer's insurer. This is intended to make those private healthcare services more affordable and accessible than they would be otherwise.

Default benefits are paid by the insurer to the hospital and are either a minimum or second-tier benefit. Figure 3 below shows a summary of the main relationships between the different types of funding and the hospital/patient service type. Eligibility requirements for second-tier default benefits are described in Section 2.2.2.2.

Figure 3: Description of default funding arrangements, by hospital/patient type



2.2.2.1 Minimum benefits

Minimum benefits are the minimum amount an insurer is required to pay for a hospital admission covered on a consumer's PHI policy[7]. The minimum amount is set by the Australian Government and is outlined in the *Private Health Insurance (Benefit Requirements) Rules 2011*. There are no

[7] Private health.gov.au. Glossary. Available from https://www.privatehealth.gov.au/footer/glossary.htm

specific eligibility requirements for hospitals to receive minimum benefits, other than to be a declared hospital. The types of services that may receive minimum benefits include:[8,9,10]

- **Type A procedures** – usually done in hospital, where the patient is given hospital treatment at the hospital for a period that includes 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).

Minimum benefits are paid when:

- A hospital is second-tier ineligible and does not have a contract with the health insurer;
- A patient only has restricted cover for their chosen health service;
- Rehabilitation, psychiatric or palliative care is provided as part of a hospital treatment and no Medicare benefit is payable for that part of the treatment; or
- A patient elects to be treated as a private patient in a public hospital (explained below).

Patients being treated in public hospitals who hold a Medicare card can elect to use their PHI to be treated as a private patient. Under the National Health Reform Agreement, private patients may be charged an amount for public hospital services as determined by the State. Second-tier default benefits only apply to private hospitals. As a result, when patients elect to use their PHI in public hospitals, the public hospital typically receives minimum benefits from the patient's insurer.

2.2.2.2 Second-tier benefits

The definition of second-tier benefits can be found in Section 1.1.

Eligibility

Eligibility for second-tier benefits includes:

- Being a private hospital;
- Being accredited against to National Safety and Quality Health Service (NSQHS);
- Not billing patients directly for minimum benefits payable by the patient's insurer;
- Making provisions for patients to provide informed financial consent; and
- Submitting Hospital Casemix Protocol (HCP) data to private health insurers for all second-tier claims.

In practice, most of these criteria apply to all accredited private hospitals. The only additional requirement for second-tier eligibility is not billing patients directly for minimum benefits.

Calculation

Second-tier default benefits are determined yearly and are no less than 85 per cent of the average charge for the equivalent episode of hospital treatment under an insurer's contracted agreements with comparable private hospitals (see Appendix B). The calculations are performed by private

[8] Private health.gov.au. Glossary. Available from https://www.privatehealth.gov.au/footer/glossary.htm

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

[10] Private Health Insurance (Benefit Requirements) Rules 2011 (Cth). https://www.legislation.gov.au/Details/F2022C00076

health insurers based on their own contracted rates. The calculations are independently audited by third parties, and the schedules of second-tier rates are provided to the Department. The Department does not have visibility of the contracts that are the basis for the calculations.

Each insurer calculates its second-tier benefit rates yearly, based on its negotiated contractual agreements in force on 1 August each year and these rates 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 7 categories as specified in the *Private Health Insurance (Benefit Requirements) Rules 2011*. The categories are:

Table 1: 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

2.2.3 Trends in funding arrangements

This section presents some quantitative outputs that illustrate the usage of different funding arrangements for admitted private patients, and how usage differs between different hospital types. These trends in funding arrangements are presented to provide context for the consultation questions in this paper.

Limitations of quantitative outputs

As part of their usual processes, the Department undergoes checks on the quality of the data provided by insurers and hospitals.

The primary data source for this study is the Hospital Casemix Protocol 1 (HCP1) dataset. HCP1 data is not complete. HCP1 completeness rates relative to data published by the Australian Prudential Regulation Authority (APRA) and the Australian Institute of Health and Welfare (AIHW) are available within the HCP Annual Report.

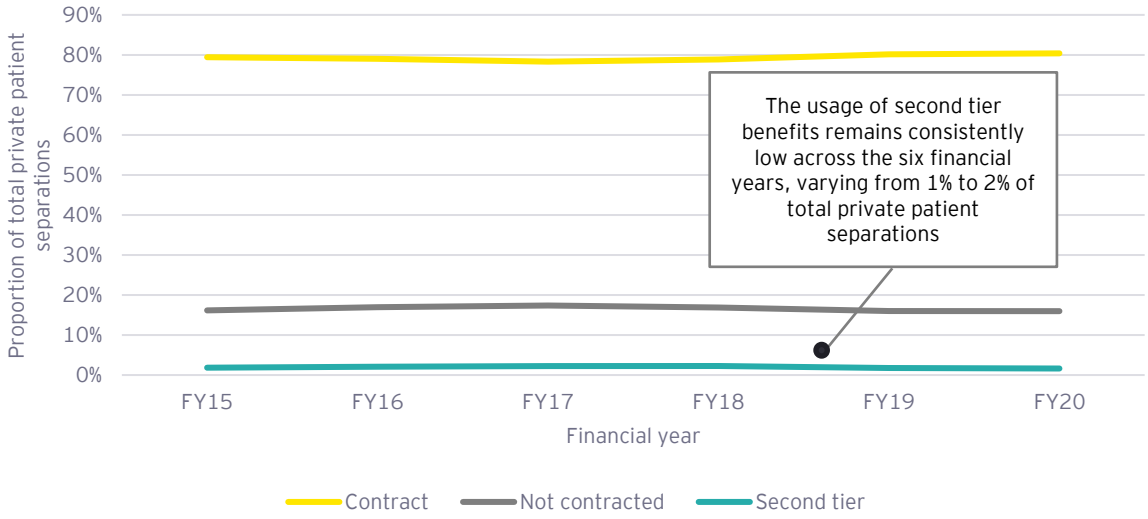
There is a definitional data limitation relating to the *hospital contract status variable* in the HCP1 dataset. The definition for the *"not contracted"* flag means it can potentially relate to hospital separations funded through any of minimum, second-tier default or contracted benefit

arrangements. It is within the scope of this study to consider whether data collection processes relating to default benefit arrangements can be improved.

For this paper, separations that have been flagged as "not contracted" within public hospitals can be interpreted as being funded by minimum default benefits.

Figure 4 represents the proportion of private patient separations in each financial year that are funded by contracts, second-tier default benefits or are not contracted. This contains private patient separations in both public and private hospitals. Most private patient separations are funded by contracted rates between the hospital and health insurer. Averaged over the six financial years, 2% of all private patient separations were funded by second-tier benefits and 16.5% were funded through "not contracted" arrangements. Across financial year 2014-15 (FY15) to financial year 2019-20 (FY20), the split between contract status remains relatively stable, with approximately 80% of private patient separations funded by contract arrangements. In FY20, the total hospital and medical benefits paid by insurers for second-tier funded separations was approximately $150 million[11].

Figure 4. Proportion of private patient separations that are paid under each contract status



Data source:

- *Processed HCP1 data supplied by the Department (extracted 15 May 2022)*

Limits and cautions in interpretation:

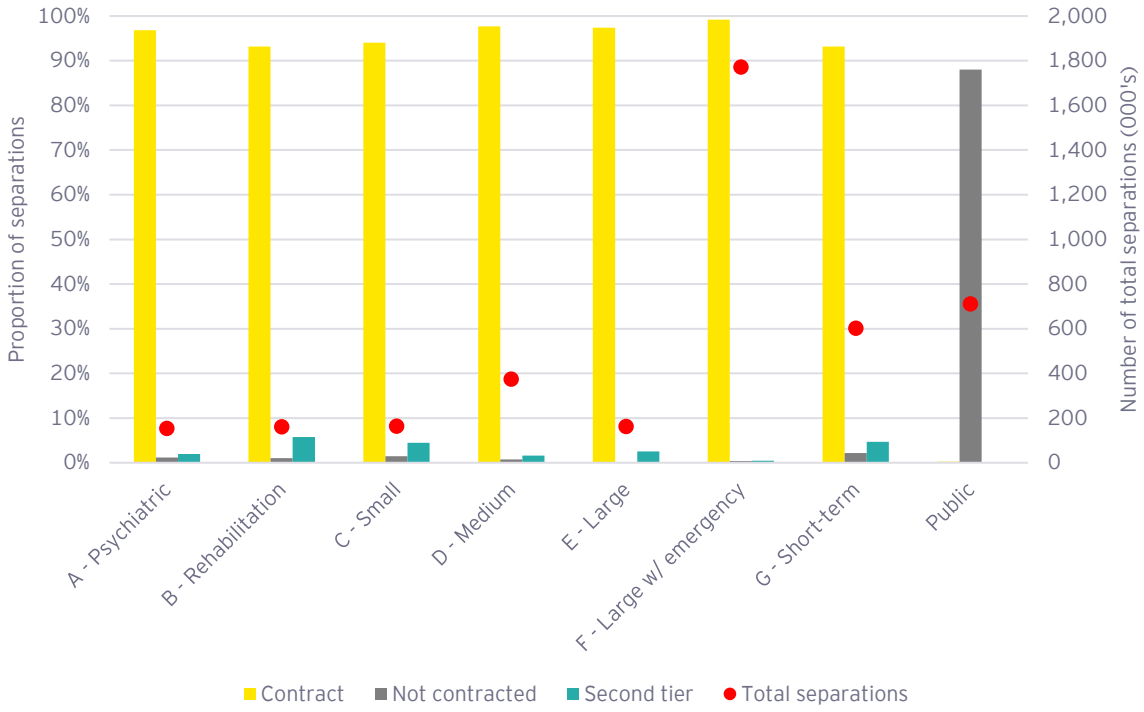
- *Due to the data quality issues in the hospital contract status flag, caution should be taken when interpreting the "not contracted" trend. More than 90% of these separations occur in public hospitals, and as such, private patient admissions in public hospitals are a primary driver of this trend.*
- *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%.*

The funding arrangement patterns in FY20 can be disaggregated by the hospital categories listed within Table 1. Figure 5 shows the number of private patient separations in each hospital category and the proportion where the hospital was paid by contracted rates, second-tier benefits or were not contracted. For private hospitals, the hospital categories represent the second-tier categories defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* and public hospitals are categorised separately.

[11] This figure was calculated as the sum of hospital benefits and medical benefits (excluding Medicare) for separations that were flagged as being funded by second-tier benefits. The data source is 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. Around 80% of separations in FY20 had a valid medical record.

Category B (rehabilitation) hospitals were funded through second-tier default benefits more frequently than the other hospital categories in FY20, while public hospitals was the category most frequently funded through minimum benefits. Category F (large hospitals with emergency departments) hospitals were almost exclusively funded through contracted arrangements.

Figure 5: Proportion of separations funded by each contract arrangement in each hospital category in FY20



Data sources:

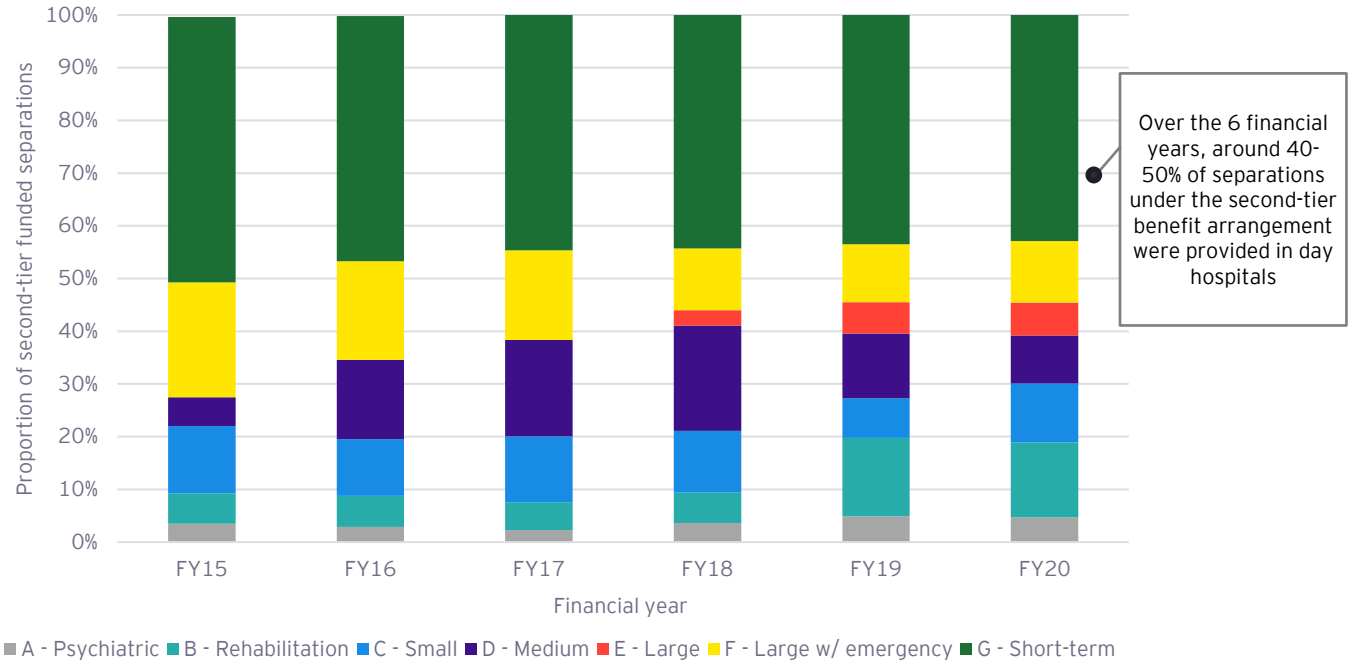
- *Processed HCP1 data supplied by the Department (extracted 15 May 2022), Private hospital second-tier category lists*

Limits and cautions in interpretation:

- *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.*
- *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%.*
- *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.*

Figure 6 shows the proportion of second-tier default benefit funded private patient separations by private hospital category, for each financial year. Category G hospitals (short term care 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 separations provided in Category B hospitals (rehabilitation hospitals), accounting for approximately 14% of separations in FY20, up from about 6% prior to FY19.

Figure 6. Proportion of second-tier funded separations in each hospital category



Data source:

- *Processed HCP1 data supplied by the Department (extracted 15 May 2022), Private hospital second-tier category lists*

Limits and cautions in interpretation:

- *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 in the classification of hospital categories.*
- *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.*

Figure 7 and Figure 8 show the proportion and number of private patient separations in private hospitals where the hospital was paid under second-tier benefit arrangements, by hospital type[12] and location for each financial year. In hospitals located in major cities, there has been a noticeable drop in separations paid under a second-tier benefit arrangement from FY18. This trend is particularly noticeable for private day hospitals, with the proportion decreasing from around 7% in FY18 to 4.5% in FY20. Private day hospitals appear to use second-tier default benefit arrangements more frequently than private overnight hospitals, with an average of 5.9% of separations paid by second-tier 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.

[12] Hospital type is identified based on the "Declared information management system hospital type" flag within the HCP1 data). We note that private day hospitals according to the "Declared information management system hospital type" flag are categorised primarily in Category G when using the hospital category lists provided (i.e. 98% of private day hospital separations were categorised in Category G across the financial years). The remaining private day hospitals fall in Category C.

Figure 7. Proportion of separations where the hospital is paid under a second-tier default benefit arrangement, by location and hospital type

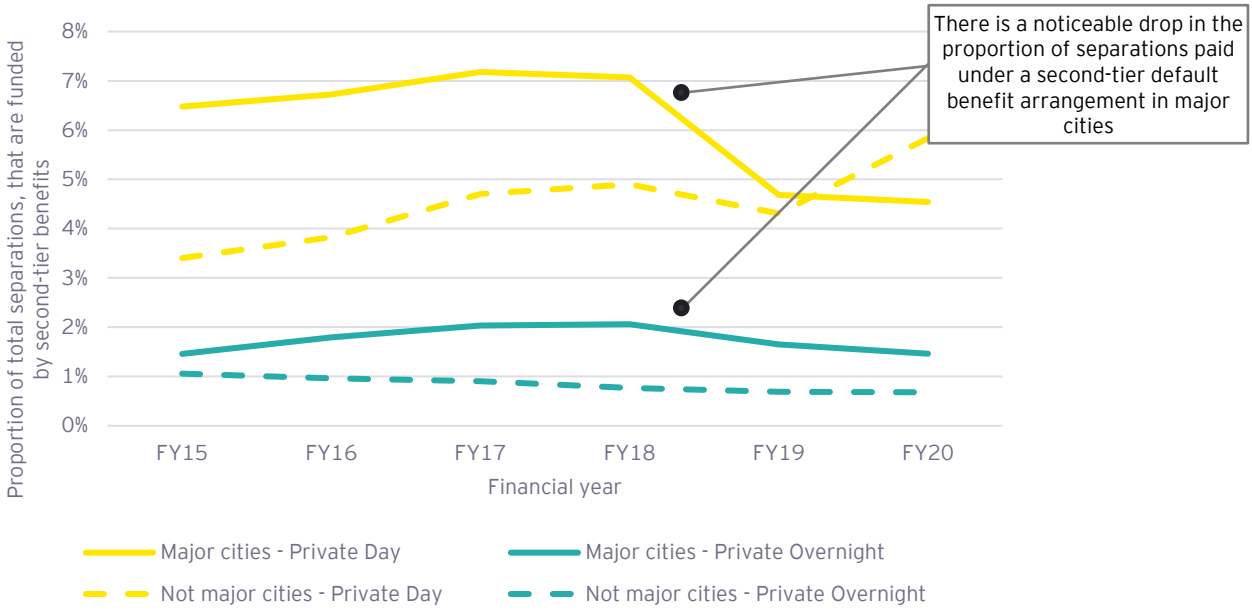
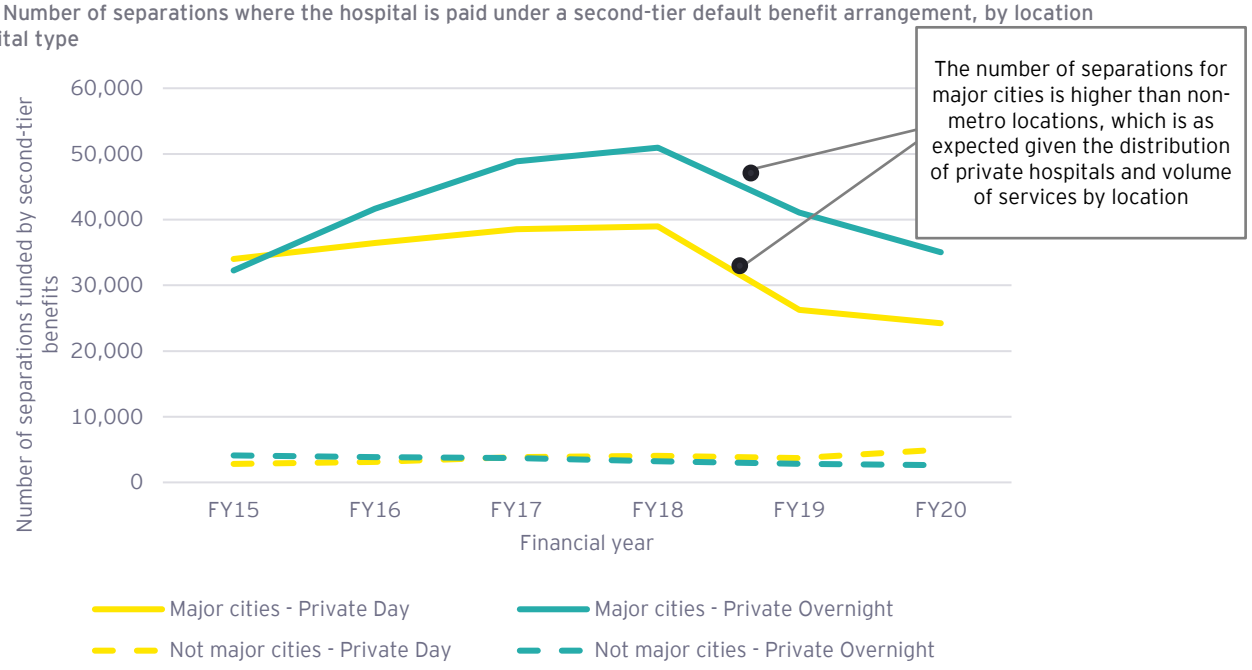


Figure 8. Number of separations where the hospital is paid under a second-tier default benefit arrangement, by location and hospital type



Data source:

- *Processed HCP1 data supplied by the Department (extracted 15 May 2022)*

Limits and cautions in interpretation:

- *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.*

2.2.4 Stakeholder perspectives on the private health insurance default benefit arrangements

Table 2 presents a high-level summary of private hospital and private health insurer perspectives relating to the strengths and limitations of the default benefit arrangements.

Table 2. Common perspectives by stakeholder group

Private Hospitals		Private Health Insurers	
Strengths	Limitations	Strengths	Limitations
▸ **Provides a safety net** – Stakeholders commented that the arrangements provide a safety net to both hospitals and consumers. ▸ **Support quality and appropriate services** – The arrangements are needed to support the delivery of private hospital services by a range of provider types for privately-insured healthcare consumers.	▸ **Operational consequences of the legislation** – The default benefit legislation has ambiguities and leads to complexities in application.	*No strengths*	▸ **Operational consequences of the legislation** – The default benefit legislation has ambiguities and leads to complexities in application. ▸ **Impacts negotiation process** – The existence of second-tier benefits creates a price floor, which impacts the negotiation process and ultimately drives up premiums. ▸ **Impacts free market dynamics** – The existence of default benefits negatively influences natural market dynamics in terms of what and where private hospitals invest.

Consultation Questions – Current funding arrangements between private hospitals and private health insurers

PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Q1. What do you see as the current objectives for default benefit arrangements?

Q2. How well do the current arrangements meet these objectives?

Q3. What other objectives should default benefit arrangements be aiming to achieve?

Q4. Do the current default benefit arrangements disincentivise contracting at all?

Q5. Should contracting between hospitals and insurers be the preferred model?
   a. If so, what are the needs for regulation relating to insurer funding of hospital services?

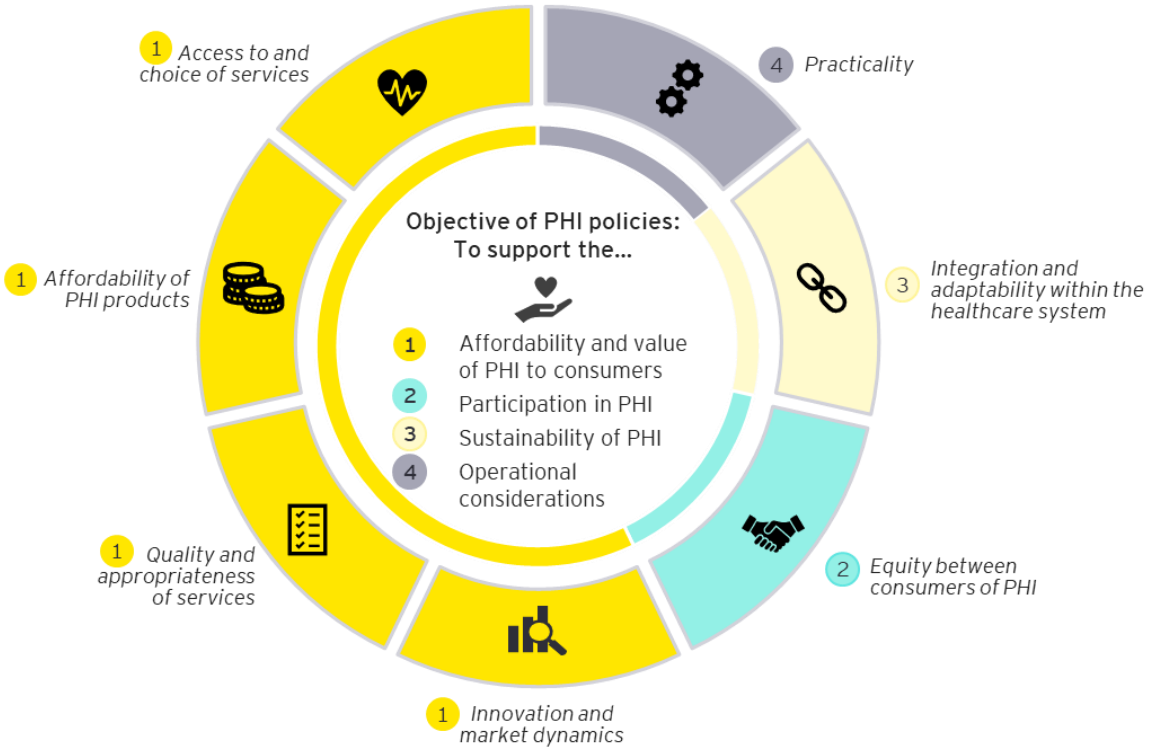
Q6. Currently, the only formal data collected that we are aware of relating to the usage of default benefit arrangements is the "Hospital Contract Status" data item in the Private Health Industry data collections (Hospital Casemix Protocol 1 and Hospital Casemix Protocol 2) submitted to the Department for collections under the *Private Health Insurance Act 2007*. What, if anything, should be done to improve the ease of data submission and the clarity and usefulness of these data collections to reflect possible payment arrangements between hospitals and insurers?

Q7. Do you have any other comments or reflections on the data presented in this section?

3. Preliminary assessment of the current default benefit arrangements

EY has created a set of assessment criteria against which to assess the current default benefit arrangements and possible future options. The assessment criteria are depicted in Figure 9 , and they support the broader objectives of contributing to the affordability and value of PHI, participation in PHI, the sustainability of PHI and operational considerations in the Australian health system. The remainder of this section describes EY's preliminary assessment of the current default benefit arrangements, using data from stakeholder consultation and other quantitative data collected to date.

Figure 9. Assessment criteria for each objective



3.1 Access to and choice of services

The purpose of this criterion is to determine the extent to which current default benefit arrangements and possible future options support access and choice of services. Key elements of access to and choice of services include:

- the density and diversity of providers in a geographic area;
- the proximity between consumers and healthcare service providers; and
- out-of-pocket costs associated with the service.

Some of the information collected to inform the current levels of access and choice is presented below.

The highest proportion of default benefits are used in major cities

Second-tier default benefits represent a small proportion of hospital separations as outlined in Figure 4 (page 9). At an aggregate system level, it appears second-tier default benefits do not

substantially contribute to services being funded through PHI, but that some private hospitals are funded through default benefits more than others. There may be areas where default benefits do play an important role from a consumer access perspective, which will be explored throughout the remainder of the study.

The highest proportion of separations funded by second-tier default benefit arrangements occur in major cities (see Figure 7, page 12). This may be due to factors associated with the default benefit arrangements themselves, or due to other factors such as patient income, travel distance, healthcare workforce availability, clinical specialist location and proximity to other necessary healthcare services. Therefore, the extent to which second-tier default benefit arrangements influence consumer access to PHI and/or patient access to insured facilities is unclear.

The data in Figure 7 (page 12) also shows that second-tier default benefits are more commonly used by private day hospitals compared to private overnight hospitals, with 4.72% of separations in day hospitals in FY20 being funded through second-tier benefits, with the balance predominantly funded through contracted arrangements.[13]

Default benefit arrangements provide a safety net in the absence of contracts

Some stakeholders noted that default benefits provide a safety net to consumers in the absence of contracts between private health insurers and private hospitals. This in turn may promote consumer confidence that they will be protected against high out-of-pocket costs if treated in a hospital that does not have a contract with their private health insurer (to the extent that they are able to perform the necessary research).

The relationship between out-of-pocket costs and contract arrangements differ by location of the hospital

Out-of-pocket costs are paid by the consumer and are in addition to any health insurance policy excesses or co-payments. Hospital out-of-pocket costs can occur due to differences in the total hospital charge for a consumer's hospital treatment and the benefit amount contributed by the insurer. Further Medical out-of-pockets costs can arise from differences in the medical practitioners' charges and the sum of the insurer medical benefit and MBS-based government contribution.

Consumers' ability to access private healthcare services is improved when out-of-pocket costs are reduced.

Private health insurers arguably have an incentive to limit out-of-pocket costs because increased costs undermine the value proposition of PHI products and tend to reflect poorly on the health insurer. Private hospitals arguably are also incentivised to limit out-of-pocket costs so that potential patients are not deterred (to the extent that potential patients are aware in advance of treatment and that this has an influence on their choice of provider).

The funding obligation on insurers created by second-tier default benefits limits out-of-pocket costs for an insured consumer at a non-contracted hospital.

However, given that, on average, private hospitals receive less from insurers under second-tier default benefits compared to contracts (by around 15% based on the formula in the legislation and assuming all else equal), it is reasonable to expect that out-of-pockets costs might be higher under second-tier default benefits compared to contracts by around the same dollar amount.

Stakeholder insights into out-of-pocket costs include that the effectiveness of default benefit arrangements in reducing out-of-pockets costs may be somewhat compromised as there is no explicit mechanism in the legislation to control them when default benefits are paid.

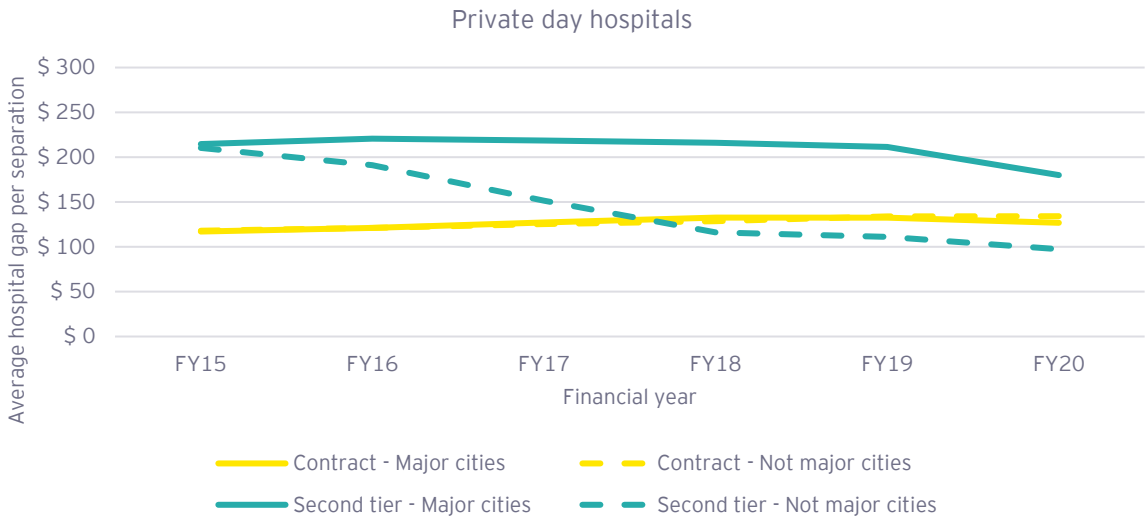
[13] Private day hospitals are identified based on the "Declared information management system hospital type" flag within the HCP1 data.

In the quantitative analysis of out-of-pocket costs, the out-of-pocket gap ('gap') is disaggregated between the hospital and medical gap. The sum of the hospital gap and medical gap equals the total out-of-pocket cost paid by the patient, which is inclusive of any excesses paid by the patient.

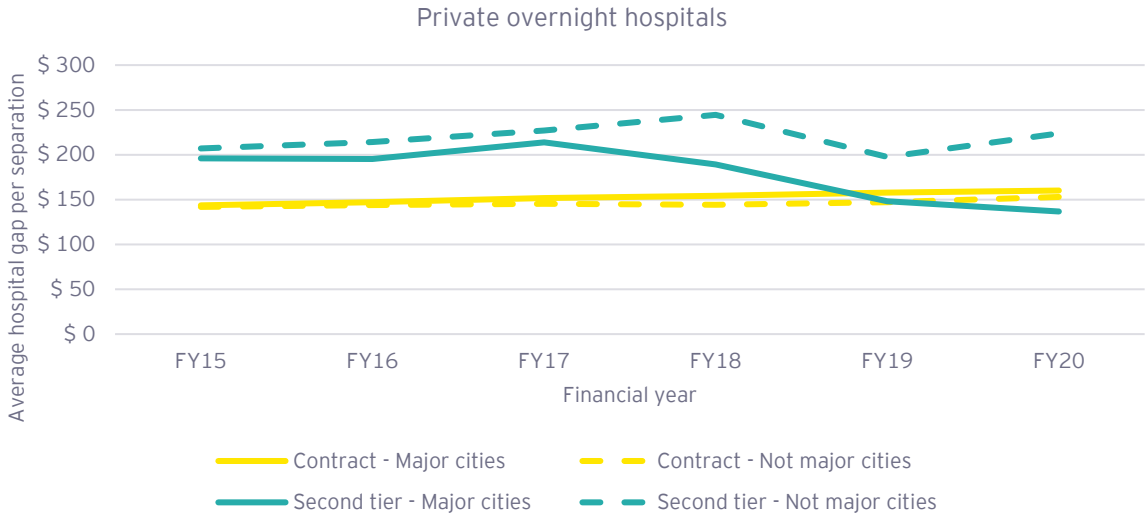
Figure 10 presents the average hospital gaps for consumers per separation from private day and private overnight hospitals. Part or all of the hospital gap may have been paid as an excess amount.[14] The charts compare the average hospital gap per separation for consumers who attended a private hospital that had a contract with their private health insurer to the separations funded by second-tier default benefits. As second-tier default benefits provide less insurer funding to private hospitals for health services compared to contracted rates, hospitals may seek to recoup funding shortfalls from consumers via increased gap payments.

This figure shows that, in day hospitals, the hospital gap is highest under second-tier default benefit funded separations in major cities. In overnight hospitals, the gap is highest for second-tier default benefit funded separations in non-major cities. In both hospital types, the average hospital gaps under contracted arrangements are similar between major and non-major cities but vary significantly under second-tier default benefits.

Figure 10: Average hospital gap per hospital separation for consumers in private day hospitals and private overnight hospitals, by contract status and location



[14] The variable description is taken verbatim from the HCP1 data specifications.
Department of Health and Aged Care. 2022. HCP1 – Insurer to Department data specifications 2022-23 – effective 1 July 2022. Available at:
https://www1.health.gov.au/internet/main/publishing.nsf/Content/1A61745E0B296274CA257BF0001B5EC4/$File/HCP1%20Insurer%20to%20Department%20data%20specifications%202022-23%20%E2%80%93%20effective%201%20July%202022.xlsx



Data source:

- *Processed HCP1 data supplied by the Department (extracted 15 May 2022)*

Limits and cautions in interpretation:

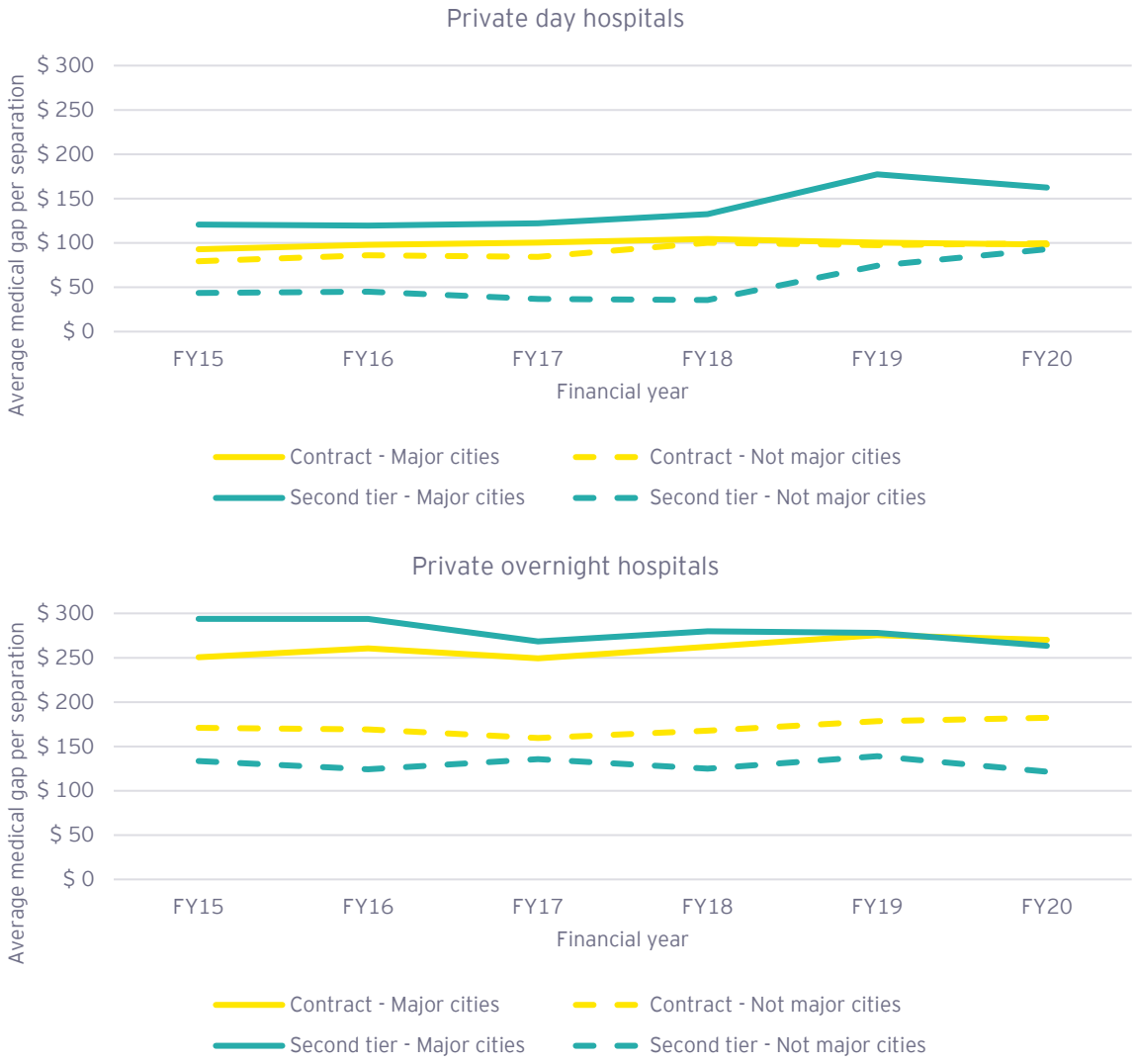
- *The hospital location categories were derived from the Modified Monash Model (MMM) categories, where a MM 1 category is major city and MM 2 to 7 were grouped to represent not major cities.*
- *The identification of hospital type is based on the "Declared information management system hospital type" flag within the HCP1 data. Private overnight hospitals refer to those with a hospital type of "private other".*
- *The hospital gap is represented as the total hospital charge minus the total hospital benefit for a separation, and the average calculation includes all separations including those with a gap of zero.*
- *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[15].*
- *There may be differences in the acuity and complexity mix of patients that may drive differences in gap amounts.*

Figure 11 presents the average medical gap for consumers per separation from private day and private overnight hospitals. Under any PHI product, insurers are obliged to pay at least 25% of the MBS fee of the procedure performed, which may or may not cover the remaining medical charges. Medical practitioners and insurers can agree 'no-gap' or 'known-gap' agreements, removing or limiting the medical gap borne by the patient.

The figures show that, in major cities, the medical gap associated with a second-tier default benefit (hospital) arrangement is generally higher than under a contracted arrangement while, in non-major cities, the medical gap is higher under contracted arrangements.

[15] Department of Health and Aged Care. 2021. Hospital Casemix Annual Reports. Available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

Figure 11: Average medical gap per hospital separation for consumers in private day hospitals and private overnight hospitals, by contract status and location



Data source:

- *Processed HCP1 data supplied by the Department (extracted 15 May 2022)*

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- *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 gap is represented as the total medical charge minus the total medical benefit for a separation, and the average calculation includes all separations with a valid medical record, including those with a gap amount of zero.*
- *Around 20% of all separations did not have a valid medical record and thus were removed from this analysis to not distort the average out-of-pockets 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[16].*

That the average out-of-pockets costs under second-tier default benefits are not multiples of those under contracted rates suggests that default benefit arrangements are somewhat effective at limiting out-of-pockets charged by private hospitals to their patients, although how the difference between the two relates to contracted rates requires further investigation. There are also situations, for example hospital gaps in private day hospitals outside of major cities and medical gaps in non-major cities, where contracted average gaps are higher than second-tier default benefit

[16] Department of Health and Aged Care. 2021. Hospital Casemix Annual Reports. Available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports

average gaps. However, this isn't a like for like comparison of similar service types under different contract arrangements, and so it is difficult to yet draw any conclusions solely from this analysis.

To better understand the drivers of differences in gap amounts and ultimately, out-of-pocket costs, the differences in the underlying services occurring under different hospital types and contract arrangements will be analysed in the remainder of the study.

Consultation Questions – *Access to and choice of services*

PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Q8. How effective are default benefit arrangements at improving PHI consumers' access to and choice of services? What other mechanisms/arrangements have an impact?

Q9. In your experience, what health services/providers are the most reliant on direct funding through default benefit arrangements?
   a. How critical are these health services/ providers to the consumer? For example, rural/remote providers, new providers, specialised/ innovative services, providers that are unable to reach any negotiated contract agreements
   b. Does reliance on default benefits arrangements change over time for these providers?

Q10. ***Option for Change*** | Do you think default benefit arrangements should be specifically targeted exclusively for the services/providers that you identified in Q9?

Q11. ***Option for Change*** | Should future options for change have two different tiers (minimum and second)? If so, what is the benefit and/or cost associated with a two-tier scheme?

Q12. How are default benefit arrangements important for hospitals that do have contracts with private health insurers, and how is this beneficial to insured patients at those hospitals?

Q13. Are you aware of examples where hospitals go from in contract to out of contract (and thus have to rely on default benefits)?

Q14. How effective are default benefit arrangements at impacting the predictability of and reducing hospital and medical out-of-pocket costs for consumers?

Q15. ***Option for Change*** | What, if any, mechanisms should be introduced to impact the predictability of and reduce hospital and medical out-of-pocket costs for consumers?

3.2 Affordability of PHI products

The purpose of this criterion is to determine the extent to which current default benefit arrangements and possible future options support the affordability of PHI products. Key elements of PHI affordability include:

- effective contract negotiations; and
- minimising administrative costs associated with complying with the legislation and processing claims that are funded under default benefit arrangements.

Information collected about effective contract negotiations are presented below. Administrative costs (for all stakeholder groups) are discussed further in Section 3.7.

Contract negotiations

In supporting access for consumers to privately insured services, default benefit arrangements should not unduly discourage contract negotiations between hospitals and insurers nor create undue additional inflationary pressure on PHI claims costs and hence premiums.

It has been suggested by stakeholders that the presence of default benefit arrangements influences contract negotiations as it both provides information to private hospitals on amounts that have been agreed with other hospitals, as well as giving confidence in the minimum amount that will be agreed. To the extent that this leads to inefficiencies it may result in insurers passing on the cost to their policy holders. However, stakeholders have noted other complexities in contract negotiations that may ultimately result in higher premiums for policy holders and or higher out-of-pockets costs.

There are several other government policies as well as industry-driven initiatives and frameworks that have been established to inform effective contract negotiations. One example of the latter is the National Procedure Banding Committee.

National Procedure Banding Committee

The National Procedure Banding Committee is a private collaboration between private hospital and private health insurer stakeholders and serves as a guide in structuring contract fees relating to some theatre procedures. Insurers and hospitals with benefit schedules that itemise theatre fees for different procedure types may refer to the findings of the committee. The Department of Veterans Affairs (DVA) also refers to the decisions of the committee to structure its contracts.

However, some insurers' benefit schedules are related to Diagnosis-Related Groups (DRGs), which bundle theatre fees with other costs such as accommodation, and therefore do not directly refer to the committee's theatre bands for any decision making. Some stakeholders also reported concerns that the current number of procedure bands (13) is not adequate for more complex surgery, and that MBS items cannot easily be moved to different procedure bands.

Consultation Questions – *Affordability of PHI products*

PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Q16. How do default benefit arrangements impact on agreed contract rates?

Q17. How does variation in contract structures and in prices agreed for similar treatments impact on prices paid for PHI by consumers?

Q18. ***Option for Change*** | What would be the implications of a published set of independently produced minimum or second-tier default benefits, from which insurers/hospitals could agree loadings/discounts in contracts? How feasible is this option and what data could be used to inform the published benefits?

Q19. What impact do other policies or institutional frameworks have on default benefits and contracting? E.g., the National Procedure Banding Committee.

3.3 Quality and appropriateness of services

The purpose of this criterion is to determine the extent to which current default benefit arrangements and possible future options support quality and appropriateness of services. Key elements of quality and appropriateness of services include:

- eligible hospitals meeting the National Safety and Quality Health Service (NSQHS) Standards; and
- the impact of contract non-price conditions.

Information collected about quality and appropriateness of services is presented below.

All services receiving contracted and default benefits are required to meet the National Safety and Quality Health Service (NSQHS) Standards. Stakeholders commented that some private health insurers also incorporate non-price conditions in their contract, which enforces additional eligibility requirements to incentivise a higher level of safety and quality. There were differing opinions on the effectiveness and implications of these additional eligibility requirements, with some viewing them as obsolete due to the already-mandatory implementation of the NSQHS Standards.

Consultation Questions – *Quality and appropriateness of services*

PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Q20. To what extent do you think the current arrangements support the safety and quality of health services?

Q21. What role does legislation and/or contracts play in ensuring quality and safety of service?

Q22. ***Option for Change*** | Should quality requirements for hospitals be broadly comparable regardless of contract status? If so, how should this be achieved?

3.4 Innovation and market dynamics

The purpose of this criterion is to determine the extent to which current default benefit arrangements and possible future options support innovation and improve market dynamics. Critical elements of innovation and improved market dynamics include:

- support for a competitive market for private hospitals; and
- support for patients to receive innovative health services.

Information collected about this criterion are presented below.

Competitive market for private hospitals

The presence of second-tier default benefits reduces some revenue risks for new private hospitals, provided they meet the eligibility criteria (*discussed in Section 2.2.2.2*). Some stakeholders suggested that second-tier default benefits may distort markets by allowing less feasible providers to enter the market, potentially leading to an over-supply of certain health care services in some geographical locations, potentially leading to a level of supplier-induced demand. Other stakeholder

groups reported the presence of new private hospitals may in the long-term create greater competition and encourage the provision of innovative health services (*discussed further below*).

Innovative health services

Stakeholders supported the concept of private health insurers enabling consumers to access more innovative health services in line with emerging clinical best practice and consumer preferences. One example of an innovative health service is Hospital in The Home (HITH), however the current second-tier default benefit arrangements only covers health services physically delivered in a hospital or hospital campus; thus limiting this service offering for consumers whose private health insurer does not have a contract with the private hospital for HITH services. This issue does not occur for public patients in public hospitals who can receive HITH funding under the National Health Reform Agreement.

According to some stakeholders, the lack of default benefit funding for innovative health services such as HITH may stifle the development and evolution of such services. However, there are notable examples where contracts between HITH providers and insurers have been agreed; implying that there may be sufficient support for innovation between contracted private health insurers and private hospitals. There are also other innovative services to consider in developing a funding solution, including hospital-substitute treatment and preventative care.

Consultation Questions – *Innovation and market dynamics*

PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Q23. Please explain any impact the current default benefit arrangements may have on the supply or demand of private hospital accommodation services?

Q24. How do the current default benefit arrangements and contracting impact the supply of other private health services, and their alignment with demand for those services? Please consider the development and provision of innovative private health services, such as HITH services, hospital-substitute treatment, and preventative care.

Q25. How can government support the sector in ensuring that evolving consumer health needs are continued to be met by the best health services and technology available at the time?

Q26. ***Option for Change*** | Does legislation relating to contracting have a role in promoting innovative health services such as HITH and how can the current legislation be improved to support innovation?

3.5 Equity between consumers of PHI

The purpose of this criterion is to support the potential reform options for the default benefit arrangements do not negatively impact equity of access to care between consumers of private health insurance. In an ideal scenario, equity between PHI consumers would be improved.

Key elements of equity of access includes:

- Choice of insurers;
- PHI products on offer and the prices of these products;
- Availability of services (e.g., distance to nearest service, choice of provider); and

- Out-of-pocket costs associated with services.

Information collected about equity between consumers of PHI is presented below.

Default benefit arrangements are intended to enable privately insured patients to access services at their hospital of choice, regardless of the presence of insurer contracts, without having to pay significant out-of-pockets costs.

The number of patients who benefit from default benefit arrangements directly (through reduced out-of-pockets costs) is relatively small (see Figure 4), however removing default benefits could have a significant impact on the patient-centred choice of affordable healthcare services for this group of patients. This will need careful consideration and further analysis, including on the population accessing these benefits (such as treatment type, out-of-pocket expenses and identification of vulnerable consumer groups requiring default benefits to support equity of access to health care services).

Consultation Questions – *Equity between consumers of PHI*
PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Q27. Which consumer groups need additional support to access private hospitals?

Q28. To what extent do default benefit arrangements support consumers to access private hospitals? Is it reasonable to expect default benefits could give more support to consumers given other limiting factors?

Q29. ***Option for Change*** | What more could/should default benefit arrangements do to support equitable access to privately insured services, or are there more appropriate arrangements to promote equity? If so, what are these arrangements?

3.6 Integration and adaptability within the healthcare system

The purpose of this criterion is to determine the extent to which current default benefit arrangements and possible future options support integration and adaptability within the healthcare system.

Ensuring a sustainable hybrid model of private and public healthcare was acknowledged as an important issue by stakeholders to allow both sectors to optimise the provision of health care services, and to support equity of access for consumers. The funding of private patients in public hospitals is a situation where the public and private healthcare systems interact. Minimum benefits (discussed in Section 2.2.2.1) are the mechanism by which insurer funding is guaranteed in this situation, noting that there are several other funding streams involving the Commonwealth Government, State and Territory governments (see Section 2.1). These enable patients to elect to be treated privately in public hospitals, providing PHI consumers a higher value proposition with their PHI policy than access to private hospitals alone. This may benefit PHI consumers in rural and regional areas without access to private hospitals to receive private hospital treatment in a public hospital and reduce the financial burden on the public healthcare system.

Stakeholders noted that the utilisation of minimum defaults in public hospitals may be associated with an administrative burden for the hospital and health insurer. Stakeholders suggested that using private health cover in public hospitals results in no material difference to the care or offering provided by the hospital, and that increased utilisation of minimum benefits may lead to increased PHI premiums.

Consultation Questions – *Integration and adaptability within the healthcare system*

PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Q30. Please comment on whether and how default benefit arrangements impact the public health system considering:
   a. its role in the funding of private patients in public hospitals
   b. the extent by which it supports patients to access private healthcare services rather than public healthcare services.

3.7 Operational considerations

The purpose of this criterion is to support consideration of the costs and inefficiencies associated with operationalising the current default benefit arrangements, as well as the practicality and feasibility of implementing any reform options.

Critical elements for consideration include:

- Administrative costs for the Department, private health insurers and private hospital providers associated with operationalising the legislation;
- Inefficiencies and inconsistencies that may arise; and
- Other consequences.

Considerations in relation to any changes include:

- Sufficient stakeholder buy-in;
- Implementation timeframes;
- Implementation costs for government, private health insurers and private hospitals of a change to policy are feasible; and
- Limited/manageable unintended consequences.

Information collected about this criterion are presented below.

Range of structures and administrative costs

In its current state, the legislation creates an administrative cost to private health insurers and private hospitals in calculating and applying the rates. Second-tier default benefit schedules for each hospital category and service category are required to be determined yearly, to be independently audited and provided to the Department. The completion of these yearly requirements and any associated costs are the responsibility of private health insurers. There is a wide variety of second-tier schedules due to various insurer contract structures.

This process is supported by an annual (regulatory) category review of hospitals undertaken by the Department.

Lack of transparency

A lack of transparency into second-tier calculations by insurers, due to private contract confidentiality, was an area of concern raised by some stakeholders.

Inconsistencies and ambiguities

Stakeholders raised concerns relating to inconsistencies and ambiguities in relation to several elements of the legislation, including the calculation of second-tier default benefits and the categorisation of private hospitals (*discussed in Section 2.2.2.2*) and eligible services.

Further ambiguities exist over the threshold for the minimum number of comparable hospitals to be included in the second-tier rates calculation (*see Appendix B*). In the case where there are fewer than five comparable hospitals in the same category and state, all private hospitals in the state are to be used to calculate the average charge. This potentially distorts the benefit calculation by grouping together quite distinct hospital types and may lead to ambiguity and inconsistency in the application of the legislation.

There are also inconsistencies in how an "equivalent episode of hospital treatment" is determined across insurers. When calculating the second-tier rates, different patient classification systems (such as Diagnosis Related Group or MBS codes) may be applied by insurers who have different rates due to the payment structures within the underlying contracts.

Other consequences

The formula for second-tier default benefits refers to all contracted rates for an individual insurer without regard to actual volumes of services funded through each contract. Stakeholders expressed concern that low or zero volume services may therefore have the potential to inappropriately skew the resulting second-tier default benefit rates.

Consultation Questions – *Operational considerations*

PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Q31. Please detail any ambiguities or other consequences that arise from the legislation in its current state that have not been described above.

Q32. ***Option for Change*** | In calculating the average charge for the equivalent episode of hospital treatment for second-tier default benefits, what are your thoughts on taking a volume-weighted approach?

Q33. ***Option for Change*** | What are your views on the current second-tier benefit hospital categories? Are there definitional issues created by these definitions - such as potential interpretations for 'rehabilitation care' in the definition of hospital category (b), and how the categories should apply to 'campuses' that are in different locations to a main facility?

Q34. ***Option for Change*** | What changes would you make to these categories?

Q35. ***Option for Change*** | Please provide details on the administrative costs associated with operationalising minimum and second-tier default benefits, highlighting any areas which are potentially inefficient.

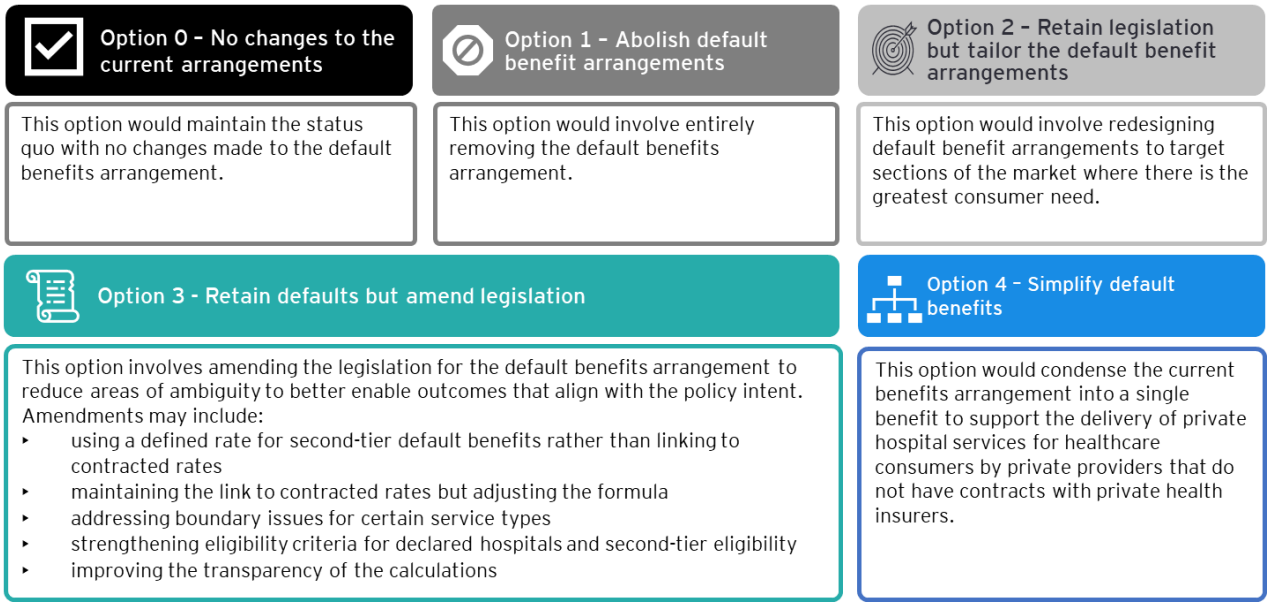
Q36. ***Option for Change*** | What options are available to improve administrative efficiency? Please consider:

a. prescribed contract templates - applicable regardless of whether default benefit arrangements apply
b. standardised terms and conditions, including in relation to quality and safety (see Section 3.3)

4. Potential future options

A high-level summary of the possible options for future default benefit arrangements are described below. These options are not mutually exclusive – i.e. it would be possible to implement a combination of some of these options. These possible options will be refined based on feedback provided to this consultation paper.

Figure 12: Summary of potential future options



The table below gives a high-level summary of the potential advantages and disadvantages of each option, noting that stakeholders have different perspectives on the validity of a number of these points.

Table 3. Potential option advantages and disadvantages

Options	Potential advantages	Potential disadvantages
Option 0 – No change to the current arrangements	▸ No impact on the current arrangements	▸ Issues that have been identified in the current arrangements will not be addressed without change
Option 1 – Abolish default benefit arrangements	▸ May encourage contracting ▸ Intended to reduce administrative costs	▸ Potentially higher out of pocket costs for some consumers ▸ Potential for hospital and insurer dynamics to favour insurers, potentially impacting amount paid for health services and access
Option 2 – Retain legislation but tailor the default benefit arrangements	▸ Intended to continue to support hospitals that most need default benefits	▸ Potential for segments of the market that rely on second-tier default

	while minimising impacts across the rest of the market	benefits to no longer have access
Option 3 Retain default benefits but amend legislation	▸ Can be designed to address and remove specific issues ▸ Presents an opportunity to align legislation with intention of the benefits and improve outcomes for consumers	▸ Significant redesign of legislation could create unintended consequences as well as transition costs
Option 4 – Simplify default benefits	▸ Simplifying to a single benefit ▸ Could remove complexity created from having two tiers of benefits	▸ Risk that the new single tier does not meet the needs of hospitals that heavily either use second-tier default benefits or minimum benefits

Consultation Questions – *Potential future options*

PLEASE PROVIDE EVIDENCE WHERE POSSIBLE

Q37. ***Option for Change*** | What specific changes would you like to see made to default benefit arrangements and what would be the benefits of these changes in relation to the assessment criteria?

Q38. ***Option for Change*** | What are the other key considerations associated with these potential changes to default benefit arrangements, including:
   a. the impacts for consumers
   b. financial and non-financial cost considerations related to implementation and ongoing administration?

5. Next steps

Thank you for responding to this consultation paper. Stakeholder input is and will continue to be a key pillar for this study and in informing the potential options for reform supporting PHI and private healthcare consumers.

The responses received from this consultation paper will inform further developments of the study, including further development of the possible future options for private health industry funding that would best support consumers in accessing private hospital services. The findings from this paper will also be used to inform further testing of ideas with stakeholders during a second round of interviews and workshops. This will include a focus on the consumer impacts of any potential change.

There will be further opportunities to consider implementation issues in more detail as reform options are developed.

Please note that EY will share your responses with the Department of Health and Aged Care and may refer to your responses in our report(s) to the Department. Neither you nor your organisation will be identified in any reports or correspondence with any other third parties. Please highlight any aspects of your response which are commercially sensitive and not to be included in our report(s) to the Department.

The completion of this study of private health insurance minimum and second-tier default benefits is scheduled for the end of 2022.

Appendix A Consultation questions

Consultation Questions

PLEASE COMMENT ON BOTH MINIMUM AND SECOND-TIER DEFAULT BENEFITS AND PROVIDE EVIDENCE WHERE POSSIBLE

Current Funding Arrangements Between Private Hospitals and Private Health Insurers

Q1. What do you see as the current objectives for default benefit arrangements?

Q2. How well do the current arrangements meet these objectives?

Q3. What other objectives should default benefit arrangements be aiming to achieve?

Q4. Do the current default benefit arrangements disincentivise contracting at all?

Q5. Should contracting between hospitals and insurers be the preferred model?
   a. If so, what are the needs for regulation relating to insurer funding of hospital services?

Q6. Currently, the only formal data collection that we are aware of relating to the usage of default benefit arrangements is the "Hospital Contract Status" data item in the Private Health Industry data collections (Hospital Casemix Protocol 1 and Hospital Casemix Protocol 2) submitted to the Department collections under the *Private Health Insurance Act 2007*. What, if anything, should be done to improve the ease of data submission and the clarity and usefulness of these data collections to reflect possible payment arrangements between hospitals and insurers?

Q7. Do you have any comments or reflections on the data presented in this section?

Access to and Choice of Services

Q8. How effective are default benefit arrangements at improving PHI consumers' access to and choice of services? What other mechanisms/arrangements have an impact?

Q9. In your experience, what health services/providers are the most reliant on default benefit arrangements?
   a. How critical are these health services/ providers to the consumer? For example, rural/remote providers, new providers, specialised/ innovative services, providers that are unable to reach any negotiated contract agreements
   b. Does reliance on default benefits arrangements change over time for these providers?

Q10. ***Option for Change*** | Do you think default benefit arrangements should be specifically targeted exclusively for the services/providers that you identified in Q9?

Q11. ***Option for Change*** | Should future options for change have two different tiers (minimum and second)? If so, what is the benefit and/or cost associated with a two-tier scheme?

Q12. How are default benefit arrangements important for hospitals that do have contracts with private health insurers, and how is this beneficial to insured patients at those hospitals?

Q13. Are you aware of examples where hospitals go from in contract to out of contract (and thus have to rely on default benefits)?

Q14. How effective are default benefit arrangements at impacting the predictability of and reducing hospital and medical out-of-pocket costs for consumers?

Q15. ***Option for Change*** | What mechanisms could be introduced to impact the predictability of and reduce hospital and medical out-of-pocket costs for consumers?

Affordability of PHI Products

Q16. How do default benefit arrangements impact on agreed contract rates?

Q17. How does variation in contract structures and in prices agreed for similar treatments impact on prices paid for PHI by consumers?

Q18. ***Option for Change*** | What would be the implications of a published set of independently produced minimum or second-tier default benefits, from which insurers/hospitals could agree loadings/discounts in contracts? How feasible is this option and what data could be used to inform the published benefits?

Q19. What impact do other policies or institutional frameworks have on default benefits and contracting? E.g., the National Procedure Banding Committee.

Quality and Appropriateness of Services

Q20. To what extent do you think the current arrangements support the safety and quality of health services?

Q21. What role does legislation and/or contracts play in ensuring quality and safety of service?

Q22. ***Option for Change*** | Should quality requirements for hospitals be broadly comparable regardless of contract status? If so, how should this be achieved?

Innovation and Market Dynamics

Q23. Please explain any impact the current default benefit arrangements may have on the supply or demand of private hospital accommodation services?

Q24. How do the current default benefit arrangements and contracting impact the supply of other private health services, and their alignment with demand for those services? Please consider the development and provision of innovative private health services, such as HITH services, hospital-substitute treatment, and preventative care.

Q25. How can government support the sector in ensuring that evolving consumer health needs are continued to be met by the best health services and technology available at the time?

Q26. ***Option for Change*** | Does legislation relating to contracting have a role in promoting innovative health services such as HITH and how can the current legislation be improved to support innovation?

Equity Between Consumers of PHI

Q27. Which consumer groups need additional support to access private hospitals?

Q28. To what extent do default benefit arrangements support consumers to access private hospitals? Is it reasonable to expect default benefits could give more support to consumers given other limiting factors?

Q29. ***Option for Change*** | What more could/should default benefit arrangements do to support equitable access to privately insured services, or are there more appropriate arrangements to promote equity? If so, what are these arrangements?

Integration and Adaptability within the Healthcare System

Q30. Please comment on whether and how default benefit arrangements impact the public health system considering:
   a. its role in the funding of private patients in public hospitals
   b. the extent by which it supports patients to access private healthcare services rather than public healthcare services.

Operational Considerations

Q31. Please detail any ambiguities or other consequences that arise from the legislation in its current state that have not been described above.

Q32. ***Option for Change*** | In calculating the average charge for the equivalent episode of hospital treatment for second-tier default benefits, what are your thoughts on taking a volume-weighted approach?

Q33. ***Option for Change*** | What are your views on the current second-tier benefit hospital categories? Are there definitional issues created by these definitions - such as potential interpretations for 'rehabilitation care' in the definition of hospital category (b), and how the categories should apply to 'campuses' that are in different locations to a main facility?

Q34. ***Option for Change*** | What changes would you make to these categories?

Q35. ***Option for Change*** | Please provide details on the administrative costs associated with operationalising minimum and second-tier default benefits, highlighting any areas which are potentially inefficient.

Q36. ***Option for Change*** | What options are available to improve administrative efficiency? Please consider:
   a. prescribed contract templates - applicable regardless of whether default benefit arrangements apply
   b. standardised terms and conditions, including in relation to quality and safety (see Section 3.3)

Potential Future Options

Q37. ***Option for Change*** | What specific changes would you like to see made to default benefit arrangements and what would be the benefits of these changes in relation to the assessment criteria?

Q38. ***Option for Change*** | What are the other key considerations associated with these potential changes to default benefit arrangements, including:

a. the impacts for consumers
b. financial and non-financial cost considerations related to implementation and ongoing administration?

Appendix B Calculation of second-tier default benefits

The rate 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 with comparable private hospitals in the State
- n = number of the insurer's negotiated agreements in force on 1 August 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 C Reliance and limitations

This consultation paper was prepared at the request of the Australian Government Department of Health and Aged Care ("the Client") solely for the purposes of conducting an independent study on private health insurance minimum and second-tier default benefits in accordance with the engagement agreement dated and signed 17 March 2022. 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, EY 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 consultation paper has been limited by time, scope and data availability. In carrying out our work and preparing this consultation paper, 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 consultation paper has been constructed based on information current as of 24 June 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 consultation paper.

Our consultation paper is based on information and data supplied by the Client. EY have not sought to verify the accuracy of data or information provided to us by the Client.

Members of EY staff are available to explain any matters presented herein to aid further understanding of the draft report. Ernst & Young does not accept any responsibility for use of the information contained in the draft 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 draft 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 D Glossary

Term	Definition
Minimum benefits *or* minimum default benefits	The lowest amount that an insurer is required to pay for a hospital admission included in a policy.
Second-tier benefits *or* 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 private health insurer calculated rates for hospital services 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*.
PHI default benefit arrangements *or* default benefit arrangements	The combination of the legislation that defines both minimum benefits and second-tier default benefits.
Department of Health and Aged Care *or* Department	The Australian Department of Health and Aged Care. Commonwealth level policy.
Per Diem	For each day. Metric of occurrence.
PHI	Private health insurance
HITH	Hospital in the home- high-level acute care provided in the consumers' home, so they do not need to stay in hospital.
Health fund	A private health insurance fund operated by a private health insurer – used interchangeably in this report
Patient	A person who receives health services
Consumer	A person who has private health insurance
Consumer Price Index	A measure of household inflation using a basket of consumer goods and services

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Our report may be relied upon by the Australian Government Department of Health and Aged Care for the purpose of the effectiveness of private hospital default benefit arrangements for private health insurance (PHI) only pursuant to the terms of our engagement letter dated 17th March 2022. We disclaim all responsibility to any other party for any loss or liability that the other 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 the other party or the reliance upon our report by the other party.

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