Australian Government

Department of Health

COST RECOVERY IMPLEMENTATION STATEMENT

Administration of Private Health Insurance
Second-Tier Default Benefits

1 July 2021 to 30 June 2022

1. INTRODUCTION

1.1. Purpose of the Cost Recovery Implementation Statement

Cost recovery involves government entities charging individuals or non-government organisations some or all of the efficient costs of a regulatory activity. This may include goods, services or regulation, or a combination of them. The Australian Government Charging Framework, which incorporates the Cost Recovery Guidelines (the CRGs)[1], sets out the framework under which government entities design, implement and review regulatory charging activities, consistent with the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

This Cost Recovery Implementation Statement (CRIS) provides information on how the Department of Health undertakes cost recovery for administration of private health insurance second-tier default benefits eligibility. It also reports financial and non-financial performance information for administration of private health insurance second-tier default benefits and contains financial forecasts for 2021-22 and three forward years. The Department of Health will maintain the CRIS until the activity or cost recovery for the activity has been discontinued.

1.2. Description of the regulatory charging activity

From 1 January 2019, private hospitals have been applying to the Department for second-tier default benefits eligibility. The Department charges these hospitals a fee to cover the cost of assessing applications and maintaining a list of second-tier eligible hospitals for use by health insurers.

The purpose of second-tier default benefits is to provide consumers with a degree of protection from high out-of-pocket costs if they are treated in a hospital that does not have a negotiated agreement with the patient's health insurer. This also assists private hospitals that are unable to negotiate an agreement with an insurer. Second-tier default benefits eligibility mostly provides access to higher benefits than would otherwise be payable where a private hospital does not have a negotiated agreement with a patient's insurer. Applying for second-tier default benefits eligibility is optional for private hospitals and requires hospitals to meet certain assessment criteria.

Prior to 1 January 2019, administration of second-tier eligibility was managed by the Second Tier Advisory Committee (STAC), chaired by the Australian Private Hospitals Association (APHA).

2. POLICY AND STATUTORY AUTHORITY TO COST RECOVER

2.1. Government policy approval to cost recover the regulatory activity

The Minister for Health, the Hon Greg Hunt MP, announced a package of reforms to private health insurance on 13 October 2017, including transferring administration of second-tier default benefits to the Department of Health. The announcement was accompanied by a

[1] The Australian Government Charging Framework and the CRGs are available on the Department of Finance website.

factsheet titled *Private health insurance reforms: Second-Tier administrative reforms*. The factsheet stated that "private hospitals choosing to apply for second-tier eligibility will pay an application fee to cover the cost of assessing their application". The policy for the reforms was approved by the Australian Government in the 2017-18 Mid-Year Economic and Fiscal Outlook in December 2017, and provides authority to fully cost recover the activity.

The application fee was introduced on 1 January 2019 when the Department commenced administration of second-tier default benefits.

2.2. Statutory authority to charge

Statutory authority to charge a fee to process applications for second-tier default benefits eligibility is provided by section 121-8 of the *Private Health Insurance Act 2007*. The amount of the fee is specified in Rule 7B of the *Private Health Insurance (Health Insurance Business) Rules*.

3. COST RECOVERY MODEL

3.1. Outputs and business processes of the regulatory charging activity

Since 1 January 2019, private hospitals have been applying to the Department for second-tier default benefits eligibility. Within 60 days of receiving an application, the Department reviews the application for completeness, assesses it against the criteria in the *Private Health Insurance (Health Insurance Business) Rules* and advises the hospital whether it is eligible for second-tier default benefits.

The Department uses the outcomes of these assessments to maintain and publish a list of all private hospitals and their second-tier eligibility status. This list is used by health insurers to calculate second-tier default benefits in accordance with the *Private Health Insurance (Benefit Requirements) Rules*.

If the Department considers that an application is likely to be unsuccessful, the applicant will be given an opportunity to provide additional information prior to a formal determination.

The Department reviews its business processes annually to ensure optimal efficiency.

3.2. Costs of the regulatory charging activity

The Department calculated the direct and indirect costs of assessing applications for second-tier default benefits and maintaining a list of private hospitals, including each hospital's second-tier eligibility status. The main cost driver for the activity is staff time required to manage the volume of applications received from private hospitals. The Department assumed that each application will take the same amount of time to assess. Staff from the APS 5 to SES Band 1 levels are involved in the process, with the bulk of the work taking place at the APS 5 and APS 6 levels to promote cost efficiency.

The Department estimated the amount of time required of each staffing level to assess an application, including associated clearances and administrative activities, based on the level of effort required for comparable activities. These time estimates were used to calculate direct costs for the activity, being the total of salaries and associated on-costs. To calculate

indirect costs, the Department multiplied these time estimates by its standard rates for training, human resources and shared services.

Table 1 shows the estimated cost to the Department of administering one application in 2021-22.

Table 1: Estimated cost of administering one application in 2021-22

Application processing	Direct Costs	Indirect Costs	Total
Receive and record application	$18	$5	$23
Check and acknowledge application	$88	$23	$111
Assessment and approvals	$450	$105	$555
Finalise assessment and advise hospital	$105	$29	$134
Publish outcome	$59	$16	$75
Total for Application Processing	$720	$178	$898

Note: Second-tier eligibility application fees are rounded to the nearest $5.

The Department estimated the volume of applications based on existing second-tier expiration and accreditation dates. Based on past trends, the Department has assumed that most hospitals with existing second-tier eligibility will re-apply when their current eligibility expires. The Department also has assumed that the administrative improvements it will deliver will encourage a small number of existing private hospitals that do not have second-tier eligibility to apply. Given recent trends, and the fact that hospitals are able to apply for second-tier eligibility at the time of applying for hospital declaration, the Department has assumed that most newly declared private hospitals will also apply for second-tier eligibility.

The Department reviews its administrative processes and estimated volume of applications each year in order to estimate the cost of the regulatory charging activity for the next financial year.

3.3. Design of regulatory charges

The Government's policy decision provides authority for the Department to fully cost recover administration of second-tier eligibility by charging a cost recovery fee to private hospitals applying for second-tier default benefits eligibility, and applying an indexation rate to the fee annually. The fee reflects the efficient cost of the service provided by the Department, as outlined in section 3.2.

Charging for this service commenced on 1 January 2019. The application fee is subject to an annual fee increase due to indexation. This application fee does not incur GST.

The application fee of $900 is payable from 1 July 2021. This fee is charged for each application and a separate application is required for each hospital. The application fee must be paid in full prior to the Department commencing assessment of an application. The Department will not waive the fee in any circumstances and the fee will only be refunded where a hospital withdraws its application prior to the Department commencing any part of assessment.

The application fee is published on the second-tier default benefits page of the Department of Health website and is listed in the application form available on the same webpage.

4. RISK ASSESSMENT

The Department continues to manage cost estimate risks by considering the costs of comparable activities it undertakes. The Department reviews its processes and cost estimates annually and will adjust if required to charge only for the efficient costs of providing this service.

5. STAKEHOLDER ENGAGEMENT

In early 2017 the Private Health Ministerial Advisory Committee – Contracting and Default Benefits Working Group discussed second-tier arrangements. At the request of members the secretariat agreed to consider whether administration of second-tier default benefits should be undertaken by the Department of Health, possibly at the point of Commonwealth hospital declaration, and if so whether the cost of undertaking this role would be recovered from industry. The final report from the Working Group supported this approach.

In early August 2018 the Department publicly consulted stakeholders, including private hospital peak bodies, about the 2018-19 CRIS.

The CRIS is updated twice a year for stakeholders:

1. prior to the commencement of the new financial year to advise the fee payable from 1 July; and
2. in November to report on the actual financial and non-financial results for the previous financial year.

Feedback on the CRIS can be provided to: phi.hospitals@health.gov.au

The Department reviews its processes and costs annually, and adjusts the application fee accordingly. Any changes to the fee, other than by annual indexation, will be consulted with the private hospital sector.

The Department has policy approval to cost recover assessment of applications and publishing of a list of second-tier default benefits eligible hospitals. Eligibility lists were previously published by the Department three or four times per year, but now that private hospitals can apply for second-tier default benefits eligibility at any time, the list is updated as the Department is advised of changes of hospital details.

The Department undertook consultation and provided information about the supporting evidence needed with applications in a guidelines document. The guidelines can be found at https://www.health.gov.au/resources/publications/second-tier-default-benefits-guidelines.

6. FINANCIAL ESTIMATES

The application fee of $900 is payable from 1 July 2021 and is indexed annually. The financial forecasts in table 2 reflect the estimated revenue and expenses, based on the annual indexation of the fee in the forward years.

Table 2: Forecast financial performance

Forecast Financial Estimates	2020-21	2021-22	2022-23	2023-24
Fee per Application	$895	$900	*	*
Expenses = X	$187,367	$71,939	$112,732	$159,481
Revenue = Y	$187,055	$72,000	$112,840	$159,160
Balance = Y - X	-$312	$61	$108	-$321
Cumulative Balance	-$11,426	-$11,365	-$11,257	-$11,578

*Financial estimates to be updated at next annual update of CRIS and application fee indexation.

The cumulative balance for 2020-21 includes the balance shown at Table 3, below.

7. PERFORMANCE

7.1. Financial Performance

Table 3: Actual financial performance

Type	Actual 2018-19	Actual 2019-20	2020-21	2021-22	2022-23
Expenses = X	$ 150,738	$ 218,226			
Revenue = Y	$ 148,750	$209,100			
Balance = Y – X	-$ 1,988	-$9,126			
Cumulative balance	-$ 1,988	-$11,114			

7.2. Non-financial performance

The following performance measures will be used to monitor the non-financial performance of administering second-tier default benefits eligibility.

Table 4: Forecast non-financial performance

Measure	2020-21 forecast	2021-22 forecast	2022-23 forecast	2023-24 forecast
Number of applications	209	80	124	173
Percentage of applications finalised within 60 days	100%	100%	100%	100%

Measure	2020-21 forecast	2021-22 forecast	2022-23 forecast	2023-24 forecast
Number of unsuccessful applications	5	5	5	5

The number of expected applications in 2021-22 is lower than past years due to the decision of the Australian Commission on Safety and Quality in Health Care (ACSQHC) to "maintain" accreditation for 12 months due to Covid-19. The second-tier approval process is aligned to the accreditation expiry date. This will result in a significant decrease in second-tier applications from January 2022 as the Department realigns hospitals with their accreditation date.

The following table will be updated after each financial year. This will enable comparison of the actual non-financial performance to the forecast non-financial performance (Table 4). Any material variances that have financial consequences will be considered in determining the application fee in future years.

Table 5: Actual non-financial performance

Measure	Actual 2018-19	Actual 2019-20	2020-21	2021-22	2022-23
Number of applications received	175	246			
Percentage of applications finalised within 60 days	100%	100%			
Number of unsuccessful applications	0	0			

These measures demonstrate the efficiency of the Department's administration of second-tier default benefits. Despite the number of applications exceeding the forecast number by 18% in 2019-20 all applications were finalised within the required 60 days.

The number of applications received is a significant cost driver. Variations in the volume of applications received by the Department impact on total costs. An inability to finalise applications within the legislated timeframe of 60 days may indicate the need for a review of administrative processes or resourcing.

The number of unsuccessful applications is an indicator of whether private hospitals understand the assessment criteria for second-tier default benefits eligibility, and could indicate a need for clearer communication by the Department. The Department aims for this to be maintained at five or fewer applications, to minimise hospitals wasting money on fees for unsuccessful applications.

To date, all applications have been processed within the 60 day timeframe and there have been no unsuccessful applications.

8. KEY FORWARD DATES AND EVENTS

Event	Date
Change to the application fee	1 July 2021
Annual update of CRIS	1 July 2021
Update of actual results for 2020-21	November 2021

9. CRIS APPROVAL AND CHANGE REGISTER

Date of CRIS change	CRIS change	Approver	Basis for change
2/09/2018	Certification of the CRIS	Glenys Beauchamp, Secretary, Department of Health	New regulatory charging activity
20/09/2018	Approval of the CRIS	The Hon Greg Hunt MP, Minister for Health	New regulatory charging activity
30/04/2019	Annual update of CRIS	Nick Henderson Assistant Secretary, Department of Health	Annual update and review
10/11/2019	Update of actual results for 2018-19	David Weiss, First Assistant Secretary, Department of Health	Update actual results and revised forward estimates
25/06/2020	Annual update of CRIS and application fee indexation.	Paul McBride First Assistant Secretary, Department of Health	Annual update and review
26/11/2021	Update of actual results for 2019-20	Paul McBride First Assistant Secretary, Department of Health	Update actual results
19/05/2021	Annual update of CRIS and application fee indexation.	Paul McBride First Assistant Secretary, Department of Health	Annual update and review