ISSUES PAPER: CONTRACTING AND DEFAULT BENEFITS

Introduction

The Minister has asked the Private Health Ministerial Advisory Committee to address regulatory issues that are adding to the cost of premiums and discouraging innovation.

The contracting arrangements between health insurers and private overnight and day only hospitals, and the minimum and second-tier default benefit regulation are regularly raised as issues by the private health sector. There are conflicting views on the impact of the default benefit regulation on the health insurer/hospital contracting environment and health insurance premiums.

This paper provides background on current private health insurance hospital contracting, minimum (basic) and second-tier default benefit arrangements, issues raised by industry and options for consideration by the Committee.

All figures in this paper are indicative estimates only and should not be quoted, or used for any purpose other than informing the Private Health Ministerial Advisory Committee. There were several assumptions applied during the analysis to address issues with the quality of available data.

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Background

Private facilities currently receive health insurance hospital benefits for the hospital treatment they provide to privately insured patients through either:

- negotiated agreements (contracts) between the facility and the insurer;
- minimum benefits, also known as 'basic default benefits'; or
- second-tier default benefits.

Contract arrangements

Since 1995 health insurers have been able to enter into commercial contracts with hospitals that detail the price they will pay for treatment of their members at that facility, along with any terms/conditions related to the payment. Contracting was introduced to enhance competition and better manage costs.

Insurers are not required to contract with all hospitals, and a contract need not include all services provided by a hospital. There is also no regulatory restriction on purchasing models, or the format, terms or conditions required in contracts.

Contracted payments are often based on an agreed episodic price, which means the health insurer and hospital are able to share the risk of varying patient length of stay.

In the absence of a contract between a hospital and an insurer, the *Private Health Insurance (Benefit Requirements) Rules,* made under the *Private Health Insurance Act 2007,* require insurers to pay benefits at least equal to the basic default benefit or the second-tier default benefit (for eligible second-tier facilities).

These are not intended to replace contracts between private hospitals and insurers and are only used in a small number of cases.

Basic default benefit

The aim of the basic default benefit is to ensure that private health insurance contributors are guaranteed some level of reimbursement for accommodation and nursing care in public and private hospitals that do not have a contract with their health insurer.

The basic default benefit is predominantly paid to public hospitals for treatment provided to privately insured patients who have elected to be treated privately.

The basic default benefit is not intended to reflect the true cost of delivering services, and therefore is not considered to discourage private facilities from seeking contracts with health insurers. Under the current Benefits Requirement Rules the basic default benefit for overnight shared ward accommodation is $343 per night on average. The benefit is adjusted annually by the Consumer Price Index.

Second-tier default benefits

The second-tier default benefit was introduced in 1997 to provide greater financial security (through a higher benefit than the basic default benefit) for private hospitals and day hospital facilities which met certain administrative and quality criteria, but were unable to obtain a contract from a health insurer/s. Its introduction was driven by concerns about health insurers commencing selective tendering and its intent was to provide a safety net for those hospitals and day surgeries that were unable to secure a contract with a health insurer. At this time, private health insurance hospital treatment membership was 32.1 per cent and there was concern about the financial viability of some private hospitals.

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The Benefit Requirements Rules *Schedule 5 – Second-tier default benefits* requires health insurers to pay non-contracted second-tier eligible facilities benefits not less than 85 per cent of the average charge for the equivalent episode of hospital treatment under that insurer's contracts with comparable facilities in the state.

Facilities wishing to be recognised as second-tier eligible must apply and be assessed as meeting the second-tier default benefit eligibility criteria by an industry based Second Tier Advisory Committee (STAC). Any private facility can apply to the STAC for second-tier recognition, regardless of its contracting status with health insurers. Once approved, the facility's second-tier eligibility expires at the end of the financial year following the date that their approval takes effect.

The criteria for second-tier eligibility are currently:

- being a private hospital declared by the Commonwealth;
- being accredited to the National Safety and Quality Health Service Standards (transitional arrangements apply);
- providing simplified billing (including having processes in place that would allow the inclusion of in-hospital medical bills in a simplified billing arrangement);
- providing informed financial consent; and

- submitting Hospital Casemix Protocol Data to health insurers electronically, where possible, with claims.

The STAC comprises three private hospital and three health insurer representatives and meets every three months whenever possible. The Australian Private Hospital Association (APHA) provides the secretariat for the STAC.

The Benefit Requirements Rules are supported by the *Administrative Arrangements for the Second Tier Default Benefits for Overnight and Day Only Treatment*.

In 2003 the government replaced the second-tier default benefit arrangements with a rural and regional default benefit (to be calculated using similar methodology to the second-tier). Non rural and regional hospitals already approved or in the process of gaining approval for second-tier retained their eligibility until June 2004 under transitional arrangements.

In 2004 the government decided to retain the second-tier default benefit, with a review scheduled for 2006. To address an argument that the second-tier benefit created a floor price for contract negotiation, health insurers were no longer required to disclose their second-tier rates to any hospital which requested them.

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Stakeholder views

Contracting and default benefits have been an ongoing area of contention in the private health sector with hospitals and insurers generally expressing opposing views.

Insurer views

Insurers argue that, providing the bargaining power is equal, contracting should deliver lower rates of inflation than would otherwise be the case if hospitals charged their 'rack rates', and also enables innovation and "the move towards value based health care arrangements".

The health insurance industry has consistently argued that the second-tier default benefit arrangements favour facilities by effectively creating an artificial 'floor price' (at 85 per cent of the average charge in contracts) for contract negotiations, which drives up hospital prices and premiums for consumers.

One submission to the 2015 private health insurance consultation wrote:

> *…ultimately, any form of distortion affecting the negotiation between providers and funds is not in the best interest of consumers, as it limits the ability to negotiate high quality, low cost outcomes.*

Insurers argue that since the introduction of the second-tier benefit market dynamics have changed, with "…significant market consolidation within private hospitals, with multi-billion dollar private hospital groups emerging." The two main hospital groups operate around 34 per cent of the private overnight hospital market. Insurers claim that this shift means the original policy objective of the second-tier benefit is no longer relevant.

Insurers also claim that large hospital groups already hold the power in contract negotiations because they contract on an 'all facilities in or all out' basis which forces insurers to pay some facilities higher benefits than they otherwise would, in order to guarantee contracts with desirable hospitals.

Health insurers also argue that it is difficult for them to reward high performing facilities with higher benefits as these flow through to the second-tier calculation, which rewards less efficient facilities and raises the 'floor price' for future negotiations.

A common view of the insurance industry is that the second-tier arrangements should only apply, at the most, to independent rural and regional private facilities rather than the entire private hospital sector.

One submission also argued that the second-tier arrangements limited consumer choice because insurers are unable to negotiate preferred provider arrangements offering higher volumes offset by lower contracted prices. It was argued that if this were the case, it would allow insurers to offer new products with lower premiums in exchange for less consumer choice about their hospital provider.

Insurers also consider that the second-tier criteria are set at a level which makes it too easy for facilities to gain eligibility, and no longer recognise a demonstrable difference in quality. In addition there are concerns that some hospitals might choose to accept the second-tier rates rather than meeting the non-price conditions required in contracts.

Health insurers claim that if the second-tier does discourage hospital contracting, it can lead to large out-of-pocket costs for consumers. This is because a non-contracted hospital receiving second-tier benefit at 85 per cent of the average contracted rate is free to determine the amount it charges for the service, with the difference passed on to the consumer.

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Hospital views

Hospitals argue that the second-tier arrangements are needed to protect the viability of private facilities, particularly in rural and regional locations, and support the continuation of a range of providers. This ensures coverage for patients at private hospitals that do not have a contract with their insurer, thereby promoting consumer choice.

Hospitals argue that the shift in the health insurance industry toward large predominantly for-profit insurers has increased the power insurers hold in contract negotiations. As at 2014-15 the top five insurers held around 81.3 per cent of the market; compared with 72.7 per cent in 1997.

Hospitals are concerned that large insurers are becoming more selective in their contracting choices and claim that insurers have chosen not to contract with some new facilities over the past two years, making the second-tier default benefit essential.

Hospitals also disagree that the second-tier arrangements discourage contracting or drive large out-of-pocket costs for consumers. One written submission stated that:

> *There are few hospital providers able to sustain a payment of 85% of the average contracted rate from any health fund that provides a significant proportion of a hospital's revenue.*

> *Where out-of-contract hospitals, in accessing second tier benefits, seek to impose an additional patient charge to compensate for the lower health fund payment, they place themselves at a significant market disadvantage compared to competitor hospitals that do have a health fund contract and do not charge additional patient out of pocket costs. So it is questionable whether the existence of the second tier scheme acts as a disincentive to hospitals to engage in good faith bargaining.*

Hospitals have also raised that some insurers may only offer a contract with prices equal to, or just above, the second-tier benefit rate, with the view that this is the most the hospital would receive if it does not enter the contract. Hospitals are arguing that second-tier is acting as a quasi-ceiling price.

Hospitals also claim that insurers game the system by negotiating contracts with providers that include low benefits for that facility's low/zero volume services. These low benefits, although not actually paid often, flow through to lower the calculated average charge used for second-tier default benefits, thereby disadvantaging non-contracted hospitals.

Hospitals have also raised that negotiating contracts with insurers is resource intensive because terms and conditions are not standard across contracts. Some submissions suggested the development of industry-wide agreed contract standards and conditions.

Hospitals also argued that insurers should be more transparent with consumers regarding their contracting arrangements. This includes advising consumers on how the range of non-contracted services and service providers will impact on them when they seek to make a claim, and about services not covered under contracts with preferred/contracted providers.

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Consumers

Consumers are unlikely to be aware of the different health insurer/hospital financing arrangements and would therefore not be expected to have strong views on the contracting or second-tier arrangements *per se*. However, consumers are implicitly concerned about any regulation, or changes to regulation, that may impact on premiums, out-of-pocket costs or consumer choice.

The contracting arrangements allow health insurers and hospitals to remove or reduce out-of-pocket costs for consumers, and also benefit consumers through non-price conditions that the hospital must meet, for example quality expectations and hospital reporting. However, the varied contracting arrangements add complexity for consumers trying to determine their level of cover for a particular treatment at a given hospital.

The Commonwealth Ombudsman managed consumer website PrivateHealth.gov.au includes an Agreement Hospitals Locator tool, where consumers can check which funds and hospitals have contracts. The website advises consumers that "when there is an agreement between your fund and your private hospital, you will have either no out-of-pocket expenses or you will be provided with details of your out-of-pocket expenses." The tool does not appear to be well known, and also does not provide information about which services are covered under a particular contract.

Australian Competition and Consumer Commission (ACCC)

In its published *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period 1 July 2010 to 30 June 2011,* the ACCC stated:

> *A typical scenario reported to the ACCC has been where a large private health insurer contracts with one hospital and declines to award a contract to another, with the latter hospital alleging it is being prevented from engaging in competitive conduct.*
>
> *If the private health insurer has sound commercial reasons for the selection of only one provider, and no proscribed anti-competitive purpose, the behaviour is not likely to be caught by the CCA [Competition and Consumer Act 2010].*
>
> *From the ACCC's perspective, there is recognition that relativities in bargaining power may affect the outcomes of HPPA negotiations and that this in itself is not unlawful. …The ACCC will continue to monitor developments in this space but notes it would appear that the increased cut and thrust of negotiating tactics and alliances between both insurer and hospital groups do not appear to be having a detrimental effect on consumers, such as an increase in premiums paid or a decrease in services obtained.*

https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2010-11

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The Private Health Insurance Administration Council (PHIAC)

In June 2015, PHIAC published its report *Competition in the Australian Private Health Insurance Market*. PHIAC described the second-tier arrangements as one of "…various safeguards in place which tend to diffuse the scope for market power to be abused along the supply chain." The report stated:

> *Second Tier pricing arrangements were originally introduced to provide a level of protection for the fragmented private hospital market when negotiating pricing arrangements with a more consolidated private health insurance industry.*
>
> *To some extent, the market determines the competitive tensions along the supply chain and generates counterbalances to equalise market forces. For instance, in recent years, there has been a broad trend of consolidation within private hospitals providing greater market strength (achieving economies of scale and scope as well as increased bargaining power), with some hospital groups now effectively 'too big' not to do business with.*
>
> *Outside of the larger hospital groups, however, the private hospital sector remains fragmented. Smaller private hospitals are not able to rely solely on Second Tier rates, but nor can they sustainably attract co-payments from patients. They are likely to be price takers in contract negotiations.*

http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Competition-in-the-Australian-PHI-market_June-2015.pdf

Administration Arrangements for the Second-tier Default Benefits

Stakeholders have also raised issues with the administration arrangements for the second-tier default benefit and governance arrangements for the STAC.

Health insurers argue the process for gaining second-tier eligibility is now process driven rather than an assessment of additional quality. They also claim that the administrative arrangements are burdensome and resource intensive for insurers. Under the arrangements health insurers are expected to devise, on an annual basis, for each state, their listing of second-tier default benefits for the upcoming year. They are also expected to have the schedules independently audited and provide copies pre- and post -audit to the Commonwealth Department of Health.

Some stakeholders have questioned whether it remains appropriate for the APHA to manage the industry based STAC, particularly given the growth in day hospital facilities and alternative peak representative bodies.

There were also concerns raised about the introduction, in 2013, of an application fee payable by facilities wishing to be considered by the STAC for second-tier eligibility, and the transparency of the setting and application of that fee. The fee was originally $907.50 (GST inclusive) and has now increased to $1210 (GST inclusive), representing an increase of 33.3 per cent since it was introduced. The fee is waived for current APHA members.

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Previous Reviews

In 2006, the Department commissioned a comprehensive review of second-tier by the Allens Consulting Group. The report recommended the retention of second-tier, revision of the categories of hospitals for second-tier calculation and that a higher level of quality and safety criteria should be adopted for second-tier eligibility. Note: A higher level of quality and safety was achieved on 3 January 2013 with the amendment of the current second-tier criteria to align with new industry wide National Safety and Quality Health Service Standards (National Standards).

A copy of the relevant section of the report is at Attachment A.

On retaining the second-tier default benefit the report stated that:

> *...although the second tier default benefit has a limited impact on the private health sector, abolishing it could have negative consequences, particularly in terms of reduced consumer choice at the margin. We, therefore, conclude that second tier default benefits should be retained. The analysis, however, further suggests that this mechanism should be used to encourage improvements in health care quality and efficiency…*

On the inflationary impact of second-tier:

> *The report concludes that second tier default benefits do not have a significant direct impact on premiums because they are paid in such a small proportion of episodes. Stakeholders were not able to provide evidence to indicate whether second tier default benefits have an inflationary effect, although both PHIAC and the PHIO noted that there could be some hospitals that have no incentives to negotiate a contract – such as smaller hospitals in rural areas – because the second tier default benefit is greater than the costs incurred. We*

conclude that second tier defaults benefit have an indirect inflationary effect on PHI premiums because they act as a price floor to hospitals for their contract negotiations.

In late 2012 and early 2013 private health insurance stakeholders provided the Department with submissions that proposed changes to the second-tier arrangements and called for a review of the regulation. The Department sought private hospital sector views on the proposed amendments. The Department considered the views from industry and undertook data analysis of recent usage of the second-tier defaults benefits. No changes were made to the second-tier at that time.

2014-15 Data

As at June 2016, 75 per cent of all declared private hospitals (including day hospitals) were second-tier eligible.

The Hospital Casemix Protocol data provides a valuable source of information about privately insured admitted patients. Although there is some 'noise' in the data it does allow an analysis of the current use of second-tier default benefits within the industry.

Use of contracts, second-tier and basic default benefits

The 2014-15 data shows that the majority (97 per cent) of private health insurance funded separations in private hospitals continue to be paid under contractual agreements between insurers and hospitals, with only a small proportion paid through the second-tier.

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In 2014-15 there were around 2.6 million private patient separations at private overnight hospitals of which around:

- 2.55 million (98.3 per cent) were paid contracted benefits
- 8,600 (0.3 per cent) were paid basic default benefits
- 36,300 (1.4 per cent) were paid second-tier default benefits.

In private day only hospitals there were over 630,000 private patient separations of which around:

- 570,500 (90.5 per cent) were paid contracted benefits
- 23,000 (3.7 per cent) were paid basic default benefits
- 36,600 (5.8 per cent) were paid second-tier default benefits.

Contracting is variable across the sector:

- 98.2 per cent of private overnight hospitals received contracted benefits for at least some of their separations
- 98.9 per cent of day only hospitals received contracted benefits for at least some of their separations
- 87.5 per cent of private overnight hospitals received contracted benefits for 90 per cent of their privately insured separations
- 62.6 per cent of private day only hospitals received contracted benefits for 90 per cent or more of their privately insured separations
- 9.3 per cent of private overnight hospitals received contracted benefits for 20 per cent or fewer of their separations

- 7.3 per cent of day hospitals received contracted benefits for 20 per cent or fewer of their separations.

This data indicates that overall use of second-tier arrangements is low and that contractual arrangements are principally being used to determine benefits.

The low use of second-tier arrangements may also suggest that health fund members are choosing to attend hospitals that have contracts with their health insurer to reduce the chance of out-of-pocket costs.

Out-of-pocket costs under second-tier default benefits

The data indicates that for second-tier separations at private overnight hospitals, the average out-of-pocket costs (excluding excesses) were between 1 and 5 per cent of the hospital's average charge per separation for 83 per cent of hospitals. At the 90th percentile average out-of-pockets costs, as a proportion of the average charge, were 9 per cent, and the highest average out-of-pocket cost was 66 per cent of the total hospital charge.

For private day only hospitals the data showed greater variation in out-of-pocket costs than for overnight hospitals. The average out-of-pocket costs (excluding excesses) were between 1 and 5 per cent of the hospital's average charge per second-tier separation for 66 per cent of private day hospitals. At the 90th percentile average out-of-pockets costs, as a proportion of the average charge, were 34 per cent, and the highest average out-of-pocket cost was 49 per cent of the total hospital charge.

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Second-tier default benefit usage in and outside of major cities

The data, at a whole of industry level, indicates that the second-tier default benefit is utilised less outside major cities.

The table below compares what proportion of second tier separations occurred outside major cities with the proportion of all separations that occurred outside major cities.

	Private Overnight Hospitals		Private Day Hospitals	
	2nd tier Separations	All Separations	2nd tier Separations	All Separations
Major cities	89%	85%	92%	87%
Outside major cities	11%	15%	8%	13%

This table shows the percentage of total separations that were paid through second-tier default benefits both in and outside of major cities.

	Private Overnight Hospitals		Private Day Hospitals	
	In Capital Cities	Outside Capital Cities	In Capital Cities	Outside Capital Cities
Percent of all separations in this location paid under 2nd tier	1.5%	1%	6.2%	3.4%

Impact of second-tier on contracting

Given the small number of episodes paid second-tier default benefits compared to contract rates, if the second-tier arrangements do have a direct inflationary impact, then the impact should not be large.

However, some stakeholders have argued that the second-tier is indirectly inflating hospital benefits paid to the private sector.

If this is the case, we can estimate the additional private hospital benefits paid annually using the benefits paid to hospitals in 2014-15 (excluding prostheses) as a base for the following rates of inflation:

- 2% = $156 million
- 1% = $78 million
- 0.5% = $39 million.

Issues for consideration

This section considers a range of issues relating to the operations and possible reform of contracting arrangements and default benefits. The issues presented are intended to guide and encourage discussion, they are not exhaustive.

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Should health insurer/hospital contracting arrangements be changed?

Should the ability for health insurers and private hospitals to enter commercial contracts remain?

The use of contracting as the primary payment mechanism for private hospitals gives rise to a number of challenges, as discussed elsewhere in this paper. To date, the policy response has been to attempt to mitigate issues which have arisen. An alternative policy approach could be to replace the entire contracting framework with a regulated benefit.

For example, hospital benefits could be set based on a private sector National Efficient Price (NEP) calculated by the Independent Hospital Pricing Authority (IHPA). To ensure the robustness of a private sector NEP, participation in the private sector National Hospital Cost Data Collection which would be used by IHPA to determine a NEP would become a condition of each facility's Commonwealth private hospital declaration. The introduction of the public sector NEP as a financial payment method for public hospital services resulted in an improvement in the data collection.

Should all health insurers and all private overnight and day hospitals be required to enter contracts?

While hospitals have raised concerns about health insurers' selective tendering processes, this is a normal part of a commercial contracting environment.

Forcing all health insurers to contract for all services with all hospitals would give hospitals unfair power in negotiations and force insurers to be price takers. This option would almost certainly drive up the price that health insurers pay for hospital treatment, and therefore premiums.

This proposal would also hinder competition, efficiency and innovation, and is likely to encourage facilities to open in areas where there is no need, increasing costs to the system overall.

If a health insurer and hospital choose to contract, should the contract be required to include all services provided at the hospital?

Currently, there is no requirement for contracts to cover all services provided by a hospital. This can be confusing for consumers who may be charged out-of-pocket costs for non-contracted services at an otherwise contracted hospital.

While requiring health insurers to contract for all services at a preferred hospital may assist consumers, it would reduce the insurer's ability to choose preferred providers for particular services based on cost and quality which may drive up premiums and reduce consumer service satisfaction. Health insurers may also be forced to pay for new services that the hospital introduces after the contract is negotiated.

Should contracts be based on standard terms and conditions?

Some stakeholders have suggested the introduction of standardised contracts to reduce administrative burden created by differences between various health funds' payments and bundling arrangements.

While forcing industry to use a standardised contract may save resources used to negotiate, it would also likely hinder innovation and efficiency within the sector.

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If contracting arrangements are unchanged, should the second-tier default benefit be retained?

Is the original policy intent of the second-tier still relevant?

The 2013 departmental review of second-tier did not question the policy intent that the second-tier should provide a financial safety net for hospitals, but rather considered the impact of second-tier on the contracting environment.

Given the private heath industry is more developed than when the second-tier was introduced in 1997, and the vast majority of hospital benefits are now paid under negotiated contracts, is there still a role for a regulated safety net for hospitals and consumers?

If so, does the second-tier default benefit regulation still meet the original policy objectives?

While 97 per cent of all private hospital episodes are paid under contracted arrangements, 75 per cent of facilities are currently second-tier eligible. This may indicate that facilities are applying for second-tier as a 'safety net' in case they do not secure a contract.

Many facilities receive contracted rates for most of their separations but receive second-tier for a small proportion of separations where they have not entered a contract, or the contract does not cover a particular service.

If a second-tier should be retained, should the arrangements be changed?

Should the second-tier eligibility criteria still recognise 'higher quality' hospitals?

Second-tier eligibility has historically been linked to a defined standard of quality and safety requirements. However, with the introduction of the National Standards, all hospitals must now meet these standards as a minimum requirement. Second-tier eligibility provides no requirement for hospitals to provide above the minimum required standards.

To reduce regulation, the current second-tier criteria could be made the minimum for all facilities. The second-tier requirements could then be made a condition of each facility's Commonwealth private hospital declaration. This could be facilitated by including the requirements in the *Private Health Insurance (Health Insurance Business) Rules* which specifies *Conditions on declarations of hospitals.*

There is an argument that the criteria should be reviewed to ensure it is still recognising facilities that offer higher than standard quality for consumers. Hospitals that do not offer higher quality would then only be eligible for the minimum basic default benefits where they have not entered a contract with an insurer.

If the eligibility criteria should be strengthened, one option may be to explore whether there are common conditions in health insurers' contracts that could be used to enhance the second-tier criteria and improve quality for consumers.

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Should the second-tier default benefit be limited to particular hospitals?

This option would reinforce the use of second-tier arrangements as a safety-net for facilities that have lower negotiating power in the current market.

Groups that could be considered are hospitals with under 200 beds, independent hospitals, rural and regional facilities and/or facilities providing specialised treatment such as psychiatric, rehabilitation, palliative or dialysis treatments.

This option may encourage more comprehensive commercial contracting in the interest of members, and reduce the administrative costs associated with processing and managing the STAC approved facility list.

Should a ceiling be placed on the amount facilities can charge patients under the second-tier arrangements?

Under the current arrangements there is no cap on what a hospital receiving second-tier benefits can charge the consumer in addition to the 85 per cent of the average contracted charge it receives from the insurer. This means that it may be possible for a hospital to receive higher total funding through the second-tier arrangements than under contracts with insurers.

Insurers have recommended a 'ceiling', possibly set at 100 per cent of the average contracted charge, be placed on the total amount a facility receiving second-tier can charge for each separation. Insurers would pay second-tier default benefits at 85 per cent of the average charge and hospitals would be able to charge consumers up to the additional 15 per cent of the average charge.

While the data indicates that most consumers are not paying large gaps for treatment under second-tier, this option would encourage lower gaps at those facilities currently charging more than 15 per cent of the average comparable contracted charge.

There are likely to be legislative constraints on the ability to implement this option.

Is the second-tier calculation still appropriate?

Health insurers argue that the current rate of 85 per cent of the average is set too high and discourages hospital contracting. On the other hand, hospitals argue that the rate should be raised, for example to 90 per cent, to ensure ongoing viability of uncontracted hospitals.

It has also been suggested that there could be different second-tier rates depending on location. For example, the 85 per cent rate could be retained for rural and regional hospitals with a new 60 per cent rate for metropolitan hospitals. This option would increase the administrative burden on health insurers as they would need to create two sets of second-tier schedules.

Some stakeholders have also recommended that when calculating second-tier benefits health insurers should only include those contracts where benefits are commonly paid for the particular service, rather than every negotiated charge. This would remove the incentive for insurers to offer low benefits to hospitals for low volume services which then reduces the second-tier calculation. However, this is likely to be administratively complex.

As an alternative, second-tier rates could be calculated based on benefits actually paid rather than contracted rates.

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Is there an alternative to basing the calculation of second-tier benefits on contracts?

An alternative to basing second tier on contracted rates may be to replace the second-tier benefit with a 'private hospital benefit' which could be set as a percentage of a private sector NEP calculated by the IHPA. As discussed earlier, it would be necessary to ensure the robustness of a private sector NEP by ensuring private hospital participation in the private sector National Hospital Cost Data Collection.

If a private hospital benefit were to replace the second-tier benefits, the percentage could initially be set having regard to the average level of the current second-tier benefit, and reviewed over time. Consideration would also be required on whether the average would be set across both day and overnight sectors, or whether averages would be needed for each sector.

Basing a private hospital benefit on a percentage of a private sector NEP may have a number of advantages:

- higher contracted rates that recognise quality hospitals would not directly flow through to uncontracted benefits;
- reduced administrative burden for health insurers calculating and auditing second-tier schedules; and
- benefits would be based on actual costs, not contracted rates that may not actually be paid.

Should insurers be required to make their second-tier schedules available to all hospitals?

Prior to 1 July 2004, health funds were required to provide their second-tier benefit rates to any private hospital or day hospital facility that requested them, regardless of the facility's contractual status or whether or not they had been approved as eligible to receive second-tier benefits. From 1 July 2004, to address concerns that the second-tier provided a floor price for contract negotiations, health funds have not been required to provide copies of their second-tier rates to hospitals. It is now up to individual health funds to determine their own arrangements regarding disclosure of their second-tier benefits to hospitals.

Are the current Administrative Arrangements still efficient?

Even if the current second-tier regulation, including eligibility criteria, remains unchanged, it would be timely to consider if the current administrative arrangements are still efficient.

Currently a facility must apply for approval that it meets the second-tier eligibility criteria to the industry-based STAC. As discussed earlier, the STAC comprises three hospital and three health insurer representatives and is chaired and administered by the APHA. An approval lasts until the end of the following financial year, and is not aligned with the facility's accreditation cycle. A facility must reapply in March/April of the year that its eligibility expires. Non-APHA members also have to pay a fee of $1210 each time they apply/reapply before their second-tier application will be considered by the STAC.

Questions for consideration may include:

- Is the STAC still the most appropriate body to consider applications for second-tier eligibility?
- If so,
    - is the structure of the STAC appropriate; and
    - given the growth in day hospital facilities, should the STAC include a day hospital representative?
- Should the STAC, or alternative body, be able to charge an application fee? If so, should all applicants be required to pay the application fee?

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