CONTRACTING AND DEFAULT BENEFITS WORKING GROUP REPORT TO THE PRIVATE HEALTH MINISTERIAL ADVISORY COMMITTEE

Introduction

On 9 November 2016, the Private Health Ministerial Advisory Committee (PHMAC) agreed to establish the Contracting and Default Benefits Working Group (the Working Group) to advise PHMAC on possible reforms covering:

- private health insurer/hospital contracting arrangements.
- the Commonwealth-determined minimum default benefit.
- the Commonwealth-determined second-tier default benefit arrangements.
- other related issues as directed by PHMAC.

The Working Group was Chaired by Mr Steve Somogyi and brought together key stakeholders with expertise in the private health insurer/hospital contracting environment to work in partnership on the development of possible reforms. Membership included insurers, private overnight and day only hospitals, industry contract negotiators, peak body and Australian Medical Association representatives and an actuary (the Working Group's full membership is at Attachment A). The following four PHMAC members were also members of the Working Group:

- Dr Rachel David
- Michael Roff
- Matthew Koce
- Jane Griffiths

The Working Group met four times over February and March 2017. There was robust discussion at each meeting, and members tabled a range of information to help inform the Working Group's deliberations. Given the short timeframe for reporting to PHMAC, not all options could be fully considered/developed. Several members were unable to attend the final meeting on 3 March 2017, but meeting papers were circulated to allow absent members to provide any comments/views to the Chair.

Mr Somogyi also met, either by phone or in person, with a number of people from the private health insurance and private hospital sectors who were not members of the Working Group, to gain their perspectives on contracting and default benefit arrangements.

The Working Group's consideration followed three overarching principles:

- Any changes to contracting or default benefit arrangements must be focused on improved benefits to consumers.
- Changes should enhance the attractiveness of private provision and reduce inflationary pressures on consumer related health care costs.
- The costs of making any changes need to be significantly outweighed by the benefits flowing from the change.

Perspectives from the Chair
In considering the need for regulation we should ask ourselves - Why do we need regulation? In essence, regulation should protect consumers, who have less information at their disposal in such highly technical areas such as private health care and health insurance, than do providers or insurers. Regulation should be the minimum required to achieve protection from this information asymmetry, without the costs outweighing the benefits.

On 15 March 2017, Mr Somogyi delivered a presentation to PHMAC on the Working Group's deliberations, and this paper provides a summary of the Working Group's views for PHMAC consideration.

This paper considers contracting, second-tier default benefit arrangements and minimum default benefit arrangements in turn. Each section provides background and issues covered by the Working Group and possible areas for reform.

Contracting

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 overnight and day only 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.

Working Group members described each sector's approach to contracting, priority areas of consideration, the aspects of contracting that were working well and also areas of challenge. The Working Group's consideration of the contracting issues raised was often constrained by confidentiality. Members advised that it was difficult for them to table evidence and data to support their position because of the confidential nature of contracts.

Perspectives from the Chair
The confidentiality constraints faced by the Working Group demonstrated how opaque is the system, which may make it difficult for some market participants to enter into meaningful contract discussions. Making business decisions based on opaque or unavailable information usually means the addition of buffers for heightened risk of mispricing and costing. This may lead to a higher than necessary rate of price inflation. This demonstrates the need for information transparency and data availability to market participants. That should enable more robust and finer margins being built in. This requires further investigation.

It appears that Commonwealth private health insurance regulation, excluding views about the second-tier default benefit which are addressed separately in the paper, is not creating barriers to contracting arrangements in the private health sector. The fact that about 97 per cent of private sector separations are paid through contracts supports this view. It is still important to consider whether there are elements of regulation, or the contracting environment, which could be reduced to lower compliance costs.

The Working Group generally supported a robust commercial contracting environment, but members agreed that the environment was challenging and likely to become more difficult. It was a common view that contracting is generally beneficial to both parties, and it is not in either sector's interest to go out of contract. In general, the issues raised about contracting, both in relation to contract content and contract negotiations, were commercial in nature and solutions will need to be industry led.

An issue that was put to the Working Group was that some day hospitals and smaller overnight hospitals have experienced difficulty in gaining contracts. There were mixed views from members on whether this is a problem, or part of a normal market operating. One view was that the day hospital sector may be able to provide day services more efficiently than larger overnight

hospitals, and that increased contracting with facilities that health insurers consider provide high quality health care outcome for their members, would lead to savings in the system. Hospital Casemix Protocol (HCP) data shows that for a number of commonly performed same day Diagnostic Related Groups (DRG) the average day hospital charge was between 54 per cent and 96 per cent of the average overnight hospital charge. The counter view was that insurers choose to contract for a range of reasons, not only price, and will make contracting decisions based on the overall balanced needs of their members.

Perspectives from the Chair This should be investigated further due to the potential significant savings available to the overall outcome.

A common issue raised by most members of the Working Group was the complexity and variation of funding models, and the range of conditions and reporting required within different contract arrangements. For example, each insurer may define quality differently, which results in hospitals having to report performance for the same service in different ways. While members agreed that variation in contracting can act to encourage/recognise innovation, it was also generally agreed that consistent performance reporting requirements would reduce the burden on hospitals, reduce non-clinical costs and benefit the whole system.

Possible areas for reform

The Working Group agreed that the Australian Commission on Safety and Quality in Health Care (ACSQHC) Private Hospital Sector Committee (PHSC) may be best placed to work with industry to develop consistent reporting requirements. It appears this work may already be within the PHSC's remit, but this would need to be formally confirmed should PHMAC wish to pursue this option. Health insurers and hospitals would need to embrace standard reporting in their contracts for system benefits to be realised.

Simplifying performance reporting and reaching agreement on what particular terminology means may assist smaller industry participants to participate meaningfully in negotiations.

The Working Group also considered whether private sector contract negotiations would benefit from peak bodies negotiating a new industry led code of practice. The Australian Private Hospitals Association and Private Healthcare Australia's predecessor (Australian Health Insurance Association) have previously negotiated a voluntary code of practice, but this has fallen into disuse.

Health insurers have indicated that they do not agree that an industry-led code of practice would improve contracting arrangements, and have argued that the Australian Competition and Consumer Commission and the Private Health Insurance Ombudsman have sufficient regulatory oversight in this area. However, given the broader potential reforms to private health insurance PHMAC may consider it timely for a new code of practice to be negotiated. This would be a voluntary code, not regulated by government.

A code of practice may also provide an opportunity for peak bodies to encourage their members to use agreed standard performance reporting in contracts. One issue that was also raised by the Working Group, and could be discussed by peak bodies in the development of a code of practice, is how to recognise established clinical guidelines in contract negotiations.

If a new code is to be developed, it is important that the entire private sector is represented through the participation of:

- The Australian Private Hospitals Association;
- Catholic Health Australia;
- Day Hospitals Australia;
- hirmaa; and
- Private Healthcare Australia.

Second-Tier Default Benefits

In 1997 the Government established "…a second-tier default benefit which would apply where there is no contract between a private hospital and a fund, but where the hospital has in place arrangements for informed financial consent and simplified billing, and evidence of an appropriate level of quality treatment."[1] Its introduction was driven by concerns about health insurers commencing selective tendering and its intent was to "give non-contract private hospitals greater financial security…."[1] At this time, private health insurance hospital treatment membership was 32.1 per cent of the population and there was concern about the financial viability of some private hospitals.

Under the second-tier arrangements health insurers 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.

Working Group members expressed a range of strongly opposing views on whether the second-tier default benefit arrangement should be retained in the private hospital/health insurer market. There was in-principle agreement, as recognised in the previous section, that any consideration of the second-tier arrangements needed to focus on consumer benefit.

> *Perspectives from the Chair*
> The opaqueness of the system is related to differential power of participants. Improved transparency of processes and price setting, while not achievable in the short term, would be a good long term outcome. This may make it easier for efficient providers to participate in the market, whether in major urban areas or in regional and rural areas.

Members discussed whether/how the existence of second-tier arrangements may impact each party's contracting decisions. Members had a range of views on whether the impact differs in times of short term contract dispute compared with when a hospital and insurer have been uncontracted long term, or when a new facility opens and contract negotiations commence.

Working Group members with expertise from the private health insurance sector generally argued that the current second-tier arrangements stop the private sector market working naturally by setting a high floor price for contract negotiations. They also raised that any regulation in this area needs to demonstrate it keeps downward pressure on premiums and minimises out-of-pocket costs to health insurance members. They argued that:

- barriers to entry for new providers into the market are already very low, and that ensuring new facilities will receive a second-tier benefit opens insurers to the risk of supplier induced demand and superfluous service providers, which unnecessarily raises premiums; and
- insurers already contract to ensure access for their members, and that portability arrangements allow consumers to move insurers if they think their fund does not contract with enough or appropriate hospitals.

[1] *Consumers to gain from private health insurance reforms,* Dr Michael Wooldridge, Media Release, 19 August 1997.

Some insurer Working Group members called for the second-tier benefit to be abolished. Other members argued the second-tier should be restricted to particular segments of the market, for example small rural and regional hospitals with demonstrable high quality outcomes that may have lower negotiating power and may need effective but not excessive downside protection.

Working Group members with expertise in the private hospital/day only hospital sector generally argued that the second-tier arrangements need to be retained to:

- help hospitals remain viable so consumers continue to have choice of service provider; and
- protect consumers from large and unexpected out-of-pocket costs if they are treated in a hospital that does not have a contract with their insurer.

Some members argued that health insurer selective contracting behaviour makes the protection of second-tier for consumers necessary.

In light of these conflicting positions, the Working Group was not able to reach agreement on the particular issue of whether or not the second-tier default benefit should be retained. This paper instead focusses on how the second-tier arrangements could be improved should the Government choose to continue a second-tier benefit.

The Working Group considered potential reforms to the second-tier benefit administrative arrangements and a number of policy options. In considering options to improve the second-tier default arrangements the Working Group aimed to increase transparency of processes, drive better quality data and remove administrative burden on the sector. Members did find common ground in a number of areas that are shown in the following table.

Possible areas for reform to improve second-tier benefit arrangements

Issue	Proposal	Benefits/considerations

<u>1. The process for gaining second tier eligibility should be updated.</u>
Currently a facility must apply for second-tier eligibility to the industry-based Second-Tier Advisory Committee (STAC). The criteria for second-tier eligibility are currently:
• being a private hospital declared by the Commonwealth;
• being accredited as fully compliant with the ACSQHC National Safety and Quality Health Service Standards (NSQHS 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 HCP data to health insurers electronically, where possible, with claims.
 	
The STAC is chaired and supported by the Australian Private Hospital Association (APHA) and comprises three hospital and three health insurer representatives. Non-APHA members pay a fee of $1210 each time they apply/reapply before their second-tier application will be considered by the STAC.
 	
Once approved, second-tier eligibility expires at the end of the financial year following the date of approval. The application and reapplication, and assessment, processes are resource intensive for hospitals and for the STAC.
 	
Members noted that the NSQHS Standards is now a requirement of all hospital accreditation, and that the Department of Health could assess second-tier eligibility during the Commonwealth declaration process.
 	
Members also generally agreed that simplified billing was not a valuable criterion as hospitals have little control over whether or not doctors want to participate in the arrangements.
	• Abolish the STAC.
	• Department of Health assess and report hospital second-tier eligibility at the same time as the initial Commonwealth declaration for health insurance purposes.
	• Link the second-tier approval period to the length of the accreditation cycle (usually three or four years).
	• Make it a condition of the second-tier benefit that if a hospital does not supply HCP data to the insurer with each claim the second-tier benefit would not be payable.
	• Remove simplified billing requirement.
	• Make it a requirement of the Commonwealth declaration that hospitals provide the Department with:
	  ○ accreditation renewal certificates; and
	  ○ notification of any accreditation issues that are identified during interim assessments, particularly if accreditation is cancelled .
	
	Longer Term
	• Work with ACSQHC to include assessment of Informed Financial Consent forms and practices as part of independent hospital accreditation.
		• Alignment with existing State licensing and declaration processes will reduce effort for private hospitals.
		• Reduction in administrative burden on industry by abolishing the STAC.
		• Improved data quality through enforced provision of HCP data.
		
		• The Department would need to consider whether the cost of undertaking the approval role would need to be recovered from industry.
		
		• One hospital member advised the sector would only support this change if costs to hospitals were not higher than current arrangements.

Issue	Proposal	Benefits/considerations
2. Produce a list of hospitals by State and hospital category The second-tier arrangements rely on hospitals being grouped with like hospitals, on the basis of size and service provision, for the calculation of each health insurer's second-tier benefit schedules and payment of benefits. There is currently no standard list of hospitals by category. Health insurers have to make their own judgement on the correct category for each hospital based on their own available data. This can result in different insurers placing the same hospital into different categories. The lack of a defined list creates confusion and inconsistency for the system, and burden for each health insurer. There was strong support from the Working Group for a central list of hospitals by category to be maintained and published.	• The Department of Health maintain and publish a list of private hospitals by State and hospital category.	• Ensure consistency in the second-tier calculation across insurers. • Improved transparency for hospitals. • Reduced administrative burden for health insurers.
3. Consider updating second-tier to reflect the Australian Institute of Health and Welfare (AIHW) private hospital peer groups Due to changes in the private hospital sector over time, the existing second-tier hospital categories may no longer appropriately group hospitals with similar resourcing requirements. For example, all day only hospitals are currently grouped together which does not reflect the different services provided by individual day only hospitals. The Working Group agreed in principle that changing the categories used for second-tier benefits to the private hospital peer groups and subgroups developed by the AIHW was worth further consideration. The Working Group also agreed that if this option was pursued the AIHW peer groups would need to be consolidated into fewer categories for the second-tier arrangements to operate effectively.	• Further explore whether the AIHW private hospital peer groups would provide a better basis for hospital categorisation for the purposes of second-tier benefits. • Engage with AIHW about how best to consolidate the private hospital peer groups for the purposes of second-tier.	• Improved transparency by aligning the second-tier categories with independent peer groups used to analyse and interpret hospital statistics. • May better align like facilities for the calculation of second-tier benefits, but may result in too few hospitals being in each category for the calculation to work effectively. • Cost of implementation, and added complexity to the arrangements, may not provide commensurate benefit.

Issue	Proposal	Benefits/considerations

<u>4. Patients should not face large short-term out-of-pocket costs under second-tier arrangements</u>
Some patients have been required to pay the entire cost of a second-tier funded service to the hospital up front and then wait for reimbursement from the health insurer.
 	
Working Group members had mixed views about the cause of this problem and also how widespread it is, but all agreed that consumers should not be required to wear short-term out-of-pocket costs as a result of second-tier benefit arrangements.
	• Make it a requirement under second-tier arrangements that:
	  ○ the insurer pays the second-tier benefit directly to the hospital; and
	  ○ the patient only pays the hospital the gap between the charge and the second-tier benefit.
		• Improve the consumer experience.
		• Members advised that this change may require some system changes but that this was not unsurmountable.

<u>5. Consumers should have access to information about hospitals' gaps under the second-tier</u> Some groups have suggested regulation of the maximum gap that can be charged under second-tier arrangements, but HCP data suggests that relatively few hospitals charge very large gaps. Only 36 out of 240 private overnight and day only hospitals charged average gaps of more than $250, and a significant number charged average gaps of less than $100. There is also a risk that regulating a ceiling on gaps may result in hospitals that currently charge less regarding the ceiling as implicit permission to charge up to that level, resulting in higher gaps for more consumers. Members generally agreed that as an alternative to setting a ceiling on gaps, information on hospitals' second-tier gaps, after front-end deductibles, be published regularly to alert consumers and doctors to where large gaps may be charged. Members did not reach a position on the best way to inform consumers. It was questioned whether information on the average second-tier gap would be useful for consumers, because their individual gap would depend on the service being provided and the insurer's second-tier benefit schedule.	• Further consider the best way to inform consumers of each hospital's typical or average second-tier related out-of-pocket costs.	• Consumers would be better informed about potential out-of-pocket costs. • Given the small number of separations paid under the second-tier arrangements, further consideration is needed on how much process can be justified to address this issue.

Issue	Proposal	Benefits/considerations
Members also discussed whether insurers have a role through their websites to provide consumers with information on provider charges, which may be an alternative or complementary way of informing consumers.		
6. The second-tier benefit should not include contracted charges for zero volume services There has been a longstanding concern from private hospital peak bodies that health insurers and hospitals negotiate contracts that agree low charges for services that the hospital does not provide, or rarely provides, and that these charges flow through to the insurer's second-tier benefit schedules. Working Group members advised that charges for these services can sometimes be set at zero. Members also discussed reasons that these charges may be included in contracts, including: • hospitals agreeing to low and zero rates for low volume services to gain higher rates for their core business; or • that charges in the contract schedules attached to contracts may default to zero for services that are not actively negotiated. Members generally agreed that the second-tier calculation should not include contracted charges that are not used in practice. This would improve transparency and remove any perceived opportunities for manipulation of contracted rates to lower the second-tier benefits. A simple solution is to remove the relevant contract charges from the second-tier calculation. Members noted that removing unused charges from the calculation would increase the complexity and burden of the calculation, but that they were not necessarily opposed to this approach. One member questioned whether low volume services should also be removed, but other members generally supported removing zero volume services.	Preferred Option – Simple Average • Remove contracted rates that have not been used for the past twelve months from the second-tier average charge calculation.	Preferred Option • It is not known how often this issue appears. Therefore, how much second-tier benefit rates will increase if unused charges are removed is also not known. • The Secretariat notes that only removing zero volume charges would keep low, but genuinely negotiated charges, in the calculation which may dampen the increase. • Retaining a simple average will likely be less inflationary than a weighted average and therefore be less likely to discourage insurers from contracting than a weighted average. • The Secretariat notes that consideration is needed on how to technically change the formula for calculating second-tier benefits to achieve this option without unintended consequences

Issue	Proposal	Benefits/considerations
Hospital members argued for moving to a weighted average based on the benefits paid rather than contract charges, but this was not supported by other members due to its potential inflationary impact. Analysis of a number of common same-day DRGs showed that the average second-tier benefit for the DRG was often less, but sometimes more, than 85 per cent of the average contracted benefit for the DRG. The Secretariat notes that this may be driven by hospitals with high volume separations weighting the average contracted rate.	Option 2 Weighted average based on benefits • Use the average benefit paid under contract in each hospital category for each Australian DRG, from which the 85 per cent second-tier would then be calculated (noting a non-DRG method could also theoretically be used). • The HCP data could be used to determine the health insurer's average benefit, inclusive of front end deductibles but exclusive of prostheses and medical benefits.	• A weighted average would likely inflate the second-tier benefit because high volume hospitals with high contracted rates would skew the calculation. • This may discourage insurers from contracting, as any higher rates they agree will have a larger inflationary impact on the second-tier than under current arrangements. • There was also concern that Option 2 would have higher implementation costs for insurers that do not currently pay on a DRG basis.

7. Alternative benefit setting option
Under the current second-tier arrangements, the benefit is directly linked to health insurers' contract. This means health insurers may be reluctant to reward high performing hospitals with higher contracted benefits because these will flow through to increase the second-tier default benefits.
 	
One member put forward an option of indexing the second-tier schedules for two years then undertaking a complete recalculation every third year based on contracts. While this option was not fully developed, members generally supported further consideration of this option.
 	
This option was put forward as a potential long term solution. It could also be implemented in the short-term as an interim arrangement should the government wish to pursue other longer term reforms.
	• Health insurers calculate the second-tier benefit schedules based on contracts every three years.
	• The second-tier benefit schedules are indexed during the two interim years by either a:
	  ○ single agreed inflation factor for the industry; or
	  ○ factor for each insurer based on their average contract increase.
	• If indexation is producing acceptable results the period between rebasing could be extended.
		• The main advantages of this option are:
		  ○ simplicity;
		  ○ low cost of implementation, particularly if an existing index is used;
		  ○ saving for insurers in calculating and auditing benefit schedules;
		  ○ more certainty for uncontracted hospitals about rates going forward.
		• Careful consideration required on the appropriate inflation factor to ensure that the differential between contracts and second-tier benefits is not eroded, which may discourage contracting.

Issue	Proposal	Benefits/considerations
Members also considered whether there would be benefit in removing the link between the second-tier calculation and the health insurers' contracts with hospitals. The Working Group considered whether the second-tier rate could be set as a percentage of the average cost of providing the DRG, determined by the Independent Hospital Pricing Authority. Most members did not support this option arguing that the amount of work involved would not result in commensurate benefits to the system. This option is described later in the paper for completeness.		• The treatment of zero volume services discussed above (Issue 6) may need to be resolved before a base year for indexing can be agreed.

Second-tier benefits - other topics considered by the Working Group

Restricting the second-tier benefit to particular segments of the market

Members had strongly opposing views on whether the second-tier default benefit should be restricted to particular segments of the private hospital/day only hospital market.

Insurer views

While some members continued to want the second-tier benefit abolished entirely, other health insurance members argued that the second-tier arrangements should only be available to hospitals with lower negotiating power, for example small independent and rural and regional hospitals.

There was a view that hospitals in rural and regional areas are more reliant on the second-tier arrangements, although this is not demonstrated in HCP benefits data which showed that proportionally the second-tier benefit is utilised more in major cities.

It was also argued that in markets with many competing hospitals, consumers do not need the protection of second-tier benefits because they can access other like services in the area and that portability arrangements allow consumers to move health insurers should their insurer not contract with the hospital they wish to attend.

Hospital views

In contrast, hospital representatives argued that the second-tier is about protecting consumers regardless of which hospital they attend. It was also raised that consumers have little choice over which hospital they attend as this decision is usually driven by their doctor of choice. One member put forward that if most hospitals are not utilising the second-tier regularly, then there seemed little reason to exclude them from the arrangement.

It was also argued that in the case of a contract dispute between an insurer and a large group hospital, many consumers are affected and they should be able to access protection using the second-tier default benefit. The counter position was that if the protection from second-tier did not exist, insurers would be unlikely to put their members at risk by going out of contract.

General view

If the government decides to limit access to second-tier, a main concern from both sides was how the eligible segments would be defined. For example, while defining regional boundaries would be easy, it is not clear how a regional hospital that is also part of a large hospital group should be treated.

Independent Hospital Pricing Authority presentation on average cost of admission

As discussed under issue seven in the above table, members considered whether there would be benefit in removing the link between the second-tier calculation and a health insurer's contracts.

One option considered, but not supported by the Working Group, was to base the second-tier benefit on the average cost of providing the DRG.

Mr James Downie, Chief Executive of the Independent Hospital Pricing Authority (IHPA) presented to the Working Group on the IHPA's key functions and pricing options. The IHPA calculates the National Efficient Price (NEP) used to determine Commonwealth funding to public hospitals. Mr Downie described for the Working Group how an average cost model could be used as an alternative to a health insurer's average contracted rates for the calculation of second-tier benefits.

This option would also improve transparency because hospitals and insurers would both know the average cost of providing the service. This might adversely affect contract negotiations where insurers seek to contract below the average cost.

There were two options considered for how the IHPA could determine average costs of providing a service in the private sector. The IHPA could:

- utilise the public sector NEP adjusted for the private sector, for example removal of medical costs (there was some concern with using public sector data in this way); or
- calculate the average cost for each DRG using the Private Sector National Hospital Cost Data Collection (Private Sector NHCDC).

If the Private Sector NHCDC was used, it would be necessary to ensure private hospitals participated in the collection to substantially increase the robustness of the of the private sector average. It is likely that basing funding on the data collection would improve the completeness and quality of data provided.

Under both options, the second-tier benefit would be a percentage, still to be determined, of the average cost. The percentage would need to be set at a level that continues to encourage contracting between parties and does not inflate benefit outlays.

Members had strong reservations about this option, particularly the amount of work involved to introduce a new benefit payment system for a small number of separations. Some of the concerns raised by members were:

- how this type of model may impact on contracting dynamics;
- how capital asset depreciation in the private sector would be considered;
- that a national average cost would not reflect State based differences in health insurer's contracts with hospitals, which feed into the premiums charged to consumers;
- how to capture the lower costs for stand-alone day hospitals;
- that hospitals may need to provide data in a format not already provided; and
- that many insurers do not currently pay benefits on a DRG basis, so this option would require system changes.

If the Government wants to pursue this or a similar option a working party would need to be established to plan and implement these changes.

Minimum 'basic' default benefits

The aim of the Commonwealth-determined minimum 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 insurer. The minimum benefits are currently set as a benefit payable per night, or per day for day only accommodation, and is based on Medicare Benefit Schedule item numbers.

The minimum 'basic' default benefit is predominately paid to public hospitals for treatment provided to privately insured patients who have elected to be treated privately. It was noted by some members that this is an increasingly important issue due to the growth in private patients in public hospitals. However, in general, the minimum 'basic' default benefit arrangements were not a priority issue for the Working Group.

The Working Group considered whether the basis of the minimum benefit could be aligned with Commonwealth activity based funding to public hospitals. This would involve setting the minimum benefit as a percentage of the average cost of providing the DRG, as described above. The appropriate percentage to apply would need to be determined to ensure that aggregate funding to hospitals under the minimum benefit was not greatly changed.

Moving to a DRG based health insurance funding model for public hospital services would improve transparency of non-State government based funding paid to public hospitals, and would provide insurers with better information on the treatments they are funding for their members.

While members were interested in exploring this idea further, they raised the same issues as those raised for the second-tier benefit. Concerns included that hospitals and insurers do not currently bill or pay for services this way, and that the benefits may not be commensurate with the costs of change.

Members also wanted to ensure that any changes to the minimum default arrangements should not discourage health insurers from contracting with public hospitals.

If the Government chose to pursue this issue, any options for regulatory or system reform to the minimum basic default arrangements would need to be considered by the Council of Australian Governments in the context of public hospital funding arrangements.

Attachment A

Membership - Contracting and Default Benefits Working Group

- Steve Somogyi, Chair
- Andrew Sando, Australian Health Service Alliance
- Luke Toy, Australian Medical Association
- Michael Roff, Australian Private Hospitals Association
- Darryl Goldman, Catholic Negotiating Alliance
- Jane Griffiths, Day Hospitals Australia
- Jamie Reid, Finity Actuaries
- Jennifer Solitario, HBF
- Cindy Shay, HCF
- Jenny Patton, Healthe Care
- Matthew Koce, hirmaa
- Scott Bell, Nexus Group
- Dr Rachel David, Private Healthcare Australia
- Allan Boston, The Bays Healthcare Group Inc.