29 September 2022

Study Manager
Ernst & Young
121 Marcus Clarke St,
Canberra ACT
2601

By email: phidefaultbenefits@au.ey.com
Cc: PHI@health.gov.au

Dear Madam/Sir

RE: Consultation Paper on Private Health Insurance Default Benefit Arrangements

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for about 15 per cent of hospital-based healthcare in Australia. Our members operate hospitals in each Australian State and in the ACT, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care. CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

The COVID-19 pandemic highlighted the critical role the private hospital system plays in supporting the health and wellbeing of Australian residents, as well as the operation of the symbiotic relationship between the public and private health systems. The public hospital system in most states could not have responded to the pandemic with such success without accessing the private system's workforce, resources and facilities. It is within this context that CHA responds to the Default Benefit Arrangements Consultation Paper.

Since COVID emerged, private hospitals have been under immense pressure across a diversity of fronts. Workforce shortages continue, with an approximate 10% vacancy rate across CHA member hospitals compounded by 10% rates of sick leave each day. Simultaneously, hospitals are struggling to manage the huge burden of costs associated with protecting patients and staff from COVID-19, influenza and continuing needs across the sector from patients who delayed diagnosis and treatment during the pandemic. The private hospital sector is stuck in a pincer movement, with ever decreasing funding from private health insurers (PHI) on the one side and ever escalating costs on the other.

It is within this context that CHA seeks to bring to your attention the very real dangers of considering changes to default benefit arrangements independently of other private health system policy levers.

Several concurrent, but disparate, reviews are now underway into the various policy carrots and sticks that support private health insurance participation. These levers are inextricably intertwined and cannot be considered in isolation. Such a fragmented approach means that, inevitably, changes to one lever will have unforeseen consequences on others. This is short-sighted, inefficient in the extreme and dangerous. The only way to ensure that good policy intentions do not lead to unintended consequences is to consider changes to the private health sector holistically.

Despite tacit agreement to this effect from the Department of Health and Aged Care and the various consultancies enlisted to perform their discrete analyses, the fact remains that half a dozen submissions are open for feedback, none of which acknowledge the others. It is imperative that decision makers acknowledge

this, as proposed reforms can have such myopic scope that more harm than good is achieved by their implementation.

Consideration must also be given to the immediate pressures under which private hospitals are operating. It is unreasonable to expect private hospitals to continue at this difficult time to participate in seemingly endless consultations, each of which considers only a small, disassociated part of the whole. It is noted that there is no evidence provided in the Consultation Paper that Default Benefit Arrangements are not working as intended, leaving the basis for this review concerningly opaque.

The private health sector faces significant macro challenges beyond the short-term crises that COVID has engendered, which are an existential threat to the viability of the sector. CHA supports careful and considered evidence-based reform to the way private health system policy levers are managed and funded in Australia, and we remain committed to working with the Government and other stakeholders on such reforms. A sound funding model for private hospitals is the foundation of private health care which in turn underpins the value proposition for private health insurance. It is time to turn our minds to the macro reforms that are required to ensure the sustainability of the private health sector.

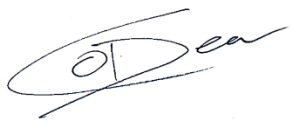
CHA proposes that consideration be given to the introduction of a National Efficient Price for care delivered in the private system. Judicious development of a Private Weighted Activity Unit could start to move the sector in this direction. Such a reform would offer a resolution pathway for the disparate reviews currently underway. It would eliminate countless inefficiencies across stakeholder groups and would provide a foundation for further ongoing reforms such as the de-politicisation of Premium Round.

That being said, we include our feedback below on the issues raised directly in the Consultation Paper. For avoidance of doubt, CHA unequivocally supports default benefit arrangements as an indispensable safety net for patients. Offering patient choice is the cornerstone of the private health sector and it is default benefit arrangements that ensure all private patients are able to exercise choice.

Given the complexity of the issues raised and default benefits' place among many other private health sector levers, CHA recommends that any suggested reforms be aggregated with other reform ideas coming out of the many other consultation processes underway. Once this is achieved, the body of work produced can be considered as an interactive whole with a view to the avoidance of damaging, but well-intentioned, mistakes. Even more importantly, such a collection of reform ideas will give a platform for further discussions and consideration of the changes needed to reimagine the patient centric private health system we want in years to come.

If you wish to discuss anything further, please contact me on 0416 918 144 or at caitlino@cha.org.au

Yours sincerely,



Caitlin O'Dea
Director, Health Policy
Catholic Health Australia

CHA feedback to the consultation paper on PHI default benefit arrangements

Default benefit arrangements are essential components of the scaffolding that supports patient access to private healthcare in Australia. The Medicare Benefits Schedule (MBS) provides minimum reimbursement levels for medical services, the Pharmaceutical Benefits Scheme (PBS) provides reimbursement levels for pharmaceuticals, and default benefits provide minimum reimbursement levels for private hospital services. Together, these three mechanisms support patients' access to and choice in their health care.

CHA is supportive of ensuring these important foundations are performing their patient support functions as best they can and it through this lens that we offer our feedback to the Consultation Paper (the Paper).

Recommendations to strengthen default benefits to maximise access and value for consumers

1. Extend default benefits to out of hospital services provided by or on behalf of private hospitals, noting:
    - Clinical standards and regulations should be consistent with hospital delivered care; and
    - Gradual introduction across clinical categories would give the sector time to adapt.
2. A one-time adjustment to minimum benefit rates to remedy historical deflation, with regular indexation to health inflation going forward;
3. Retain Second Tier benefits with some tweaks to application, methodology and transparency:
    - Recognise all accredited hospitals as Second Tier eligible;
    - The Department of Health and Aged Care to calculate volume weighted Second Tier schedules annually using Hospital Casemix Protocol (HCP) data; and
    - Second Tier rates to be published.
4. If an intervention into the operations and scope of the Theatre Banding Committee is to be considered, the Independent Health and Aged Care Pricing Authority (IHACPA) should be enlisted to review the bands and allocation methodology; and
5. Ensure any reform options consider the suite of interconnected policy levers that support patients to access private health care services, of which default benefits are only one part.

Valuing private healthcare

Of concern have been comments by some stakeholders in the recent industry consultative forums to the effect that a significant underlying driver of the reform proposal is increasing health insurance premiums. While expenditure on health care needs to be undertaken with prudence and premiums kept affordable, cost minimisation must not become the sole measure of success.

Health inflation is typically higher than Consumer Price Index (CPI) inflation, often considerably so. There are also several other factors contributing to the increase in health insurance premiums. Not least that from FY19-FY22, private health insurers spent an extra 8.3% ($2.6 billion) managing themselves while hospital claims paid only increased 0.6%[1]. The ageing of the insured population, increases in the costs of medical technologies, cost pressures from keeping hospital patients and staff COVID-safe, as well as staff wage pressures are some of the other factors influencing the cost of delivering heath care services. CHA contends these pressures will necessarily continue, further validating that the primary driver of any reform to the private health sector must be to increase value to patients.

[1] Derived from quarterly PHI APRA data https://www.apra.gov.au/quarterly-private-health-insurance-statistics

Value in this context should consider in equal weighting, the scope and depth of consumers' access to private health services, the contribution of this care to health outcomes and experience, and its financial cost.

DEFAULT BENEFITS ARE A CONSUMER SAFETY NET, ENABLING ACCESSIBILITY AND CHOICE IN THE RECEIPT OF PRIVATE HEALTH SERVICES

A patient-centred approach to private health

Regrettably, as evidenced by Figure 9, the Paper puts private health insurance at the centre of its review rather than consumers. This has the potential to skew responses. A patient-centric principles-based approach could consider the following in the first instance:

- Reform must support patient choice
- Reform must minimise patient out-of-pocket costs
- Reform must minimise complexity for patients, funders and providers
- Reform must improve transparency
- Reform must improve responsiveness to change
- Reform must achieve value for all stakeholders
- Reform must progress the sustainability of the private health sector.

Questions 1, 2 & 3 – The role of default benefits in underpinning access to private health care

Default benefits are a consumer safety net, enabling accessibility and choice in the receipt of private health services. Specifically, default benefit arrangements ensure consumers:

- Can access subsidised care at non-contracted hospitals; and
- Can access subsidised care for non-contracted services.

Without default benefits, this access would be put at risk as:

- Medical and hospital out of pocket costs would increase;
- Some hospitals and services would become unsustainable; and
- Investment and innovations would become more difficult to enact.

In the immediate term, default benefit arrangements ensure patients can use their health insurance to receive a private health insurance contribution to receiving care at the location of their choosing. As with the type and extent of treatment, private health insurers have no business dictating where they prefer treatment to take place – these are decisions for patients and their clinicians.

In the medium to longer term, default benefits improve patient access to new services, innovations and care models as they give hospitals some security to invest in these innovations. While the hospital is still required to do the upfront investment and heavy lifting, default benefit arrangements ensure patients will be able to access the service once complete, by confirming private health insurers must pay a base amount for their members to access services and cannot withdraw all financial support.

There are significant opportunities to expand the value of private health care through incorporating out of hospital (OOH) services into default benefits arrangements. OOH models of care are an opportunity to address pressure on the health system and meet patient preferences for more flexible care. Compared to

traditional inpatient care for medically stable patients, OOH care can often be more efficient and effective, with lower readmission rates, length of stay, mortality, and increased patient satisfaction.[2]

OOH care has the potential to fundamentally improve the capability and efficiency of the private health system. However, economies of scale can only be achieved with the funding certainty for hospitals to invest broadly and deeply into these services, which can be delivered through an expansion of default benefit arrangements.

Question 4 – The role of default benefits in contracting

There is no evidence presented in the Paper that the existence of default benefit arrangements has any detrimental impact on contracting outcomes. Rather, private hospitals should be recognised for delivering a high quality health system with only modest price increases.

As seen in the Paper, private hospital care is largely funded through contracted arrangements. According to September 2022 data[3], 80% of private hospitals hold Second Tier status yet the Paper notes only 2% of private patient separations over the previous six financial years utilised Second Tier benefits. This demonstrates that contracting between private health insurers and private hospitals is the prevailing state of affairs.

As second tier arrangements were designed as a safety net for patients when hospitals were unable to contract with a private health insurer, it is reasonable to expect only a minority of private hospitals to find themselves in this position. Well targeted default benefits incentivise hospitals to contract with insurers by paying a typically reduced level of accommodation benefits to the hospital and increasing medical and hospital out of pocket costs for patients, making the hospital less attractive over the long term.

One case study[4] demonstrates the difficulties even large providers can have when attempting to contract with health insurers, and most of the private hospital market is owned by small or medium sized operators (there are over 515 private hospitals in Australia outside those operated by the two largest providers).

Question 5 – Alternative model for regulating private health insurer funding of hospital services

The Paper notes "private hospitals and private health insurers generally agree that contractual arrangements are the preferred type of funding arrangement," which is true as the present alternative to a contract is a reduced second tier rate.

It is incumbent on all stakeholders though to consider alternatives to the status quo. It would be possible to overhaul the system of privately funded services and replace it with a judiciously developed weighted national efficient price for the private system. This would negate the need for time consuming and administratively burdensome contracting as we now know it, and would offer a way to bring together the many concurrent reviews underway. It would also offer a platform for future reforms to the private health sector which, given the macro pressures the system is facing, are unavoidable.

An alternative contracting model could also be informed from learnings from the Department of Veterans' Affairs approach. The Department of Veterans' Affairs has relied upon well-reasoned and updated inputs to calculate State specific indexation offers. This process has existed for several years and is based upon factors such as utility costs, labour cost and average EBA increments across all workforce categories, consumable costs and other general costs. The process is transparent and conducted by an independent 'big four' accounting firm, with calculations are provided for review. More recently, the Department of Veterans'

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[2] https://www.cha.org.au/wp-content/uploads/2021/03/6-CHA-Report-J170720.pdf
[3] https://www1.health.gov.au/internet/main/publishing.nsf/Content/hospitals2.htm
[4] https://documents.uow.edu.au/~bmartin/dissent/documents/health/healthscope_bupa.html#final%20word

Affairs has benchmarked pricing parameters across the sector with some price contraction made to realign to an overall bandwidth. The Department of Veterans' Affairs has an aged population of veterans who require medical and surgical care that is often extended due to their underlying fragility. The Department of Veterans' Affairs has ensured that the need for national access for veteran care (supporting the veterans' choice of services) is maintained and promoted by having a consistent approach to funding together with a single national contract and a good relationship with providers to ensure veteran and their family needs are met. Private hospital providers can opt in to contracted arrangements – or opt out. Objectives supported under this scenario are transparency of price offer/indexation; access to services; single public agreement – consumers, providers can source information relating to the funding arrangements – with no hospital or medical out of pocket costs for veterans.

Question 8 – Other mechanisms impacting consumers' access to and choice of services

As mentioned previously, default benefits are only one part of a suite of health insurance policy levers that work together to support private health insurance participation and fairness for all parties. Community rating, risk equalisation, mental health waivers, Lifetime Health Cover, youth discounting, Medicare Levy Surcharge, extended age limits, and the private health insurance rebate are other levers that impact consumers' access to and choice of private health services.

Patients' access to and choice of services is also impacted by activity-limitation clauses commonly mandated by health insurers in their contracts with hospitals. For example, such clauses often limit activity above a specified threshold after which health insurance funding is withdrawn and/or reimbursement by the hospital to the health insurer for services delivered to patients is exacted.

Asymmetric negotiations or 'price taking' is a consequence of annual to tri-annual re-contracting negotiations for small and medium private hospital providers. There is no formal calculation utilised or base level funding expectation applied to health insurers and they remain the gatekeeper of all funding. A health insurer can set their own investment and financing policies in relation to hospital funding with enormous price variation for like-for-like services existing across the sector (small, medium, large, rural, regional and metro – State and Territory differentials). With new funding pressures emerging post-COVID it is likely that the sector will become more adversarial without greater transparency. Health insurers as recipients of taxpayer funds should be compelled to publicly report non-contracted services (for example a mental health unit within an acute private hospital) and/or non-contracted hospitals (for example clinician owned day surgeries) to avoid 'policy making' being disguised as a commercial objective – and ultimately limiting choice and access. Specific data flags could be added to HCP collections if greater specificity was required by the Department. This could include:

- Default rates flagged against episodes funded (for example restricted benefit coverage for mental health, rehabilitation, palliative care; or where new services are not funded by health insurers); and
- Second tier default flag against all episodes utilising these rates.

Question 15 – Out of pocket costs

The most common out of pocket costs charged to consumers are private health insurer generated excess and/or co-payments, and medical out of pockets. Notably, the overwhelming majority of separations from contracted hospitals do not include out of pocket costs imposed by the hospital.

Without default benefit arrangements patient out of pocket costs would undisputedly increase. Firstly, the current default benefit, rather than being reimbursed by private health insurance, would instead be charged to patients. The average minimum benefit for a surgical hospital stay under two weeks is $437. This is the minimum amount out of pockets could be expected to increase if default benefits were removed or substantially weakened. Secondly, given *no and known gap* medical fee schemes (Medical Purchaser Provider

Agreement arrangements) typically only occur at contracted hospitals, a removal or weakening of default benefit arrangements would also interact with these schemes to increase medical out of pocket costs to patients.

Default benefit indexation and the deteriorating financial environment for private health services

Indexation of minimum benefit rates has not kept pace with health inflation. Table 1 below shows this most clearly with minimum benefit rates from 2012 to 2022 increasing 24% but private health insurance average premiums increasing 53% over the same period. For hospitals with unfunded services relying upon minimum benefits, these rates have failed to keep pace with health inflation, placing an increasing out of pocket cost burden upon consumers. Consumers with health insurance policies that include restricted benefits for services such as palliative care, mental health and rehabilitation are particularly impacted by this.

To reduce the patient out of pocket costs this historical deflation has generated, a one-off readjustment of minimum benefit rates and a realignment of indexation to health inflation going forward is required.

Table 1. Impact of indexation on minimum default benefits over a decade
Minimum overnight accommodation rates for private patients at private hospitals in all States/Territories 2012-2022
Derived from *Private Health Insurance (Benefit Requirements) Rules 2011*

	2012 Benefit	2022 Benefit	% change (average 1.7%/yr)	If indexation occurred at the same rate as PHI premium increases (53% overall, average 4.4%/yr)	Disparity between 2022 actual Benefit and Benefit if indexed to PHI Premium inflation
Advanced surgical					
1 to 14 days	$384	$476	24%	$588	$112 (23%)
>14 days	$266	$331	24%	$407	$76 (23%)
Surgical or obstetric					
1 to 14 days	$356	$441	24%	$545	$104 (24%)
>14 days	$266	$331	24%	$407	$76 (23%)
Other					
1 to 14 days	$356	$383	8%	$545	$162 (42%)
>14 days	$266	$331	24%	$407	$76 (23%)
Mental health					
1 to 42 days	$356	$441	24%	$545	$104 (24%)
43 to 65 days	$309	$383	24%	$473	$90 (23%)
>65 days	$266	$331	24%	$407	$76 (23%)
Rehabilitation					
1 to 49 days	$356	$441	24%	$545	$104 (24%)
50 to 65 days	$309	$383	24%	$473	$90 (23%)
>65 days	$266	$331	24%	$407	$76 (23%)

Minimising out of pocket costs

There are opportunities to improve the function of default benefits arrangements to minimise out of pocket costs and improve transparency of fees.

Out of pocket costs can be reduced by reforming the current binary state that hospitals are either a second tier or contracted facility. Instead, where hospitals hold second tier status, hospital services that are rejected for contracted funding by private health insurers should qualify for second tier funding. This would improve patient access to services, reduce patient out of pocket costs, reduce administrative burdens, simplify funding arrangements, and would better support hospitals in the delivery of care patients need, rather than only that which health insurers agree to contract for.

Consideration could also be given to thoughtfully moving the Medical Costs Finder website to a compulsory disclosure model, ensuring patients are able to universally access medical out of pocket cost information.

Further transparency and guidance from health insurers as to which clinicians participate in no-gap or known gap arrangements and under which conditions would also assist.

Affordability of private health insurance

Affordability of private health insurance has many *'key elements'* and it is inappropriate to focus on default benefit arrangements above and separate to others. It is particularly alarming the Paper does this given default benefit arrangements provide consistency of access to consumers without impacting overall healthcare costs.

Minimising private health insurer management expense costs is a key omission of the Paper, with these costs increasing 8.3% over the past three years as compared to hospital claims paid, which only increased 0.6%[5]. Similarly, contracting for services delivered more efficiently out of hospital is the greatest opportunity to improve efficiency of and access to the private health sector and is not considered in detail by the Paper.

The omission of these two key issues is significant as no analysis has been completed outside of the limited definition offered as to what impacts the affordability of private health insurance.

Question 18 – What would be the implications of a published set of independently produced minimum or second-tier default benefits, from which insurers/hospitals could agree loadings/discounts in contracts?

If the proposal is to abolish the payment of default benefits but to retain their calculation for publishing online as non-enforceable guidelines for contracting, that would retain all the administrative burden but none of the consumer benefit.

Regarding availability of the Second Tier Schedules, with private hospitals increasingly becoming price takers in a private health market dominated by a small number of large health insurers, visibility of second tier schedules is required. If, as has been claimed by some stakeholders, contracted hospitals have significant obligations placed upon them which are not required of second tier facilities, hospitals and consumers should have visibility of the second tier schedules to level the negotiating playing field and ensure those increased expectations are renumerated appropriately.

Question 19 – What impact do other policies or institutional frameworks have on default benefits and contracting? E.g., the National Procedure Banding Committee?

The National Procedure Banding Committee (NPBC) is an industry reference point and does not set rates. Rather, it allocates MBS items to bands which are used in hospital and health insurer contracts. Second tier rates are different in that they should reflect what is happening in the market. It is worth noting that the

[5] Derived from quarterly PHI APRA data https://www.apra.gov.au/quarterly-private-health-insurance-statistics

NPBS is a voluntary and consensus driven group that functioned well for a long time. It is only now, as health insurers are increasingly disregarding the Committee's decisions, despite their having equal representation on the Committee, that some (not at all insurmountable issues) have arisen. The MBS review process has not helped this, with new MBS items being created without consideration of the practicalities in executing those new items.

If consideration is being given to countering these issues, CHA proposes the Department enlists IHACPA to do a review of the current bands and the methodology used to arrive at those bands. This would ensure banding decisions can be validated, and the review could consider whether the existing 13 bands are sufficient. The IHACPA review would be binding, with suggestions adopted by the Committee. Going forward, a robust mathematical model, which accounts for the relativities between MSAC pricing and the MBS, should be developed to assist in banding new items.

These steps would resolve current pain points within the current NPBC framework, without the need to create a formalised group, nor create a formalised arbitration pathway.

THERE ARE SIGNIFICANT OPPORTUNITIES TO EXPAND THE VALUE OF PRIVATE HEALTH CARE THROUGH INCORPORATING OUT OF HOSPITAL SERVICES INTO DEFAULT BENEFIT ARRANGEMENTS.

Question 22 – Should quality requirements for hospitals be broadly comparable regardless of contract status? If so, how should this be achieved?

Bespoke safety and quality clauses add dozens of pages to hospital contracts and add an excessive extra administrative burden on hospitals for no proven gain. It would help immensely if health insurers could align on a standard set of extra criteria. CHA strongly suggests the Australian Commission on Safety and Quality in Healthcare (ASQHC) standards should be accepted as sufficient for this purpose.

If health insurers and/or the Department are of the view that the ASQHC standards are not sufficient, the ASQHC standards should be revisited and increased to a level agreeable by all stakeholders.

The submission of HCP data is prescribed in legislation, offers immediate transparency of services provided and is a rich source of direct patient quality and safety performance information. Data provides insight into readmission rates, hospital acquired complications, underlying existing diseases, surgical and non-surgical interventions, clinician, outcomes and patient demographics such as age and length of stay. The current application process for second tier eligibility only serves to ratify and confirm what is already established by the Commonwealth hospital declaration process with no obvious benefit for the consumer. Health insurers in receipt of HCP data, are open to analyse it to satisfy themselves of a hospitals' performance. Similarly the Commonwealth Department of Health can perform this role. The punitive nature of some health insurer arrangements in tackling the difficult question of patient variability against quality and safety metrics has created much angst across the sector. In order to fund quality services, pricing needs to reflect an appropriate investment. Introducing quality and safety reporting metrics for second tier status facilities would be appropriate as a method to ensure continuous quality improvement of services but would need to be carefully considered.

Question 26 – The importance of OOH care in increasing value

Private health insurance funding should facilitate the provision of care in the most appropriate setting based on patients' preferences and clinical needs, yet the current regulatory environment limits guaranteed

funding to care delivered in hospital. It is clear that achieving the widespread provision of care in the most appropriate setting for each patient requires an expansion of default benefit arrangements.

A number of treatments and care types such as dialysis, chemotherapy and palliative care that previously needed to take place within a hospital can now, in certain circumstances, safely take place in other settings. Where a patient prefers to receive care at home and clinical assessment deems it appropriate, health insurance funding should logically follow. Provided that treatment is efficacious, safe, cost-effective, and meets the requirements and preferences of the patient and their treating clinician, the existence or otherwise of private health insurance funding should not be the determining factor as to where treatment takes place.

Default benefit arrangements must evolve to fix this oversight that is restricting patient access to clinically effective, cost effective, patient centric care, while ensuring safety and quality remain paramount. Services must not be permitted to move from a hospital to another setting which has lower standards of safety and quality. Hospitals impose accreditation and scope of practice limits on practitioners who work in their facilities, which are over and above the requirements of State/Territory legislation. Hospitals also impose strict infection control standards and policies, have rigorous incident reporting and management protocols, and can ensure continuity of care and back-up in the event of an adverse outcome. A less regulated environment could provide an opportunity for corners to be cut and patient care to suffer. For these reasons, default benefit arrangements should only be extended to OOH care performed by or on behalf of a hospital.

With the advancement of technology, changes in surgical approach, the advent of new medicines and changing patient preferences, there continues to be a shift from overnight to same day care and to out of hospital admitted and non-admitted care. Unlike the public sector, private hospitals are often restricted from providing 'the right care in the right location' simply because funding is not agreed or it is not permitted under current legislation. While some health insurers fund these services, many do not support hospital in the home services outside those they are able to provide themselves either directly or via a subcontractor. Others do not contract with hospitals for these services citing concerns around benefit outlay, quality considerations, and/or necessity.

ONE CHA MEMBER HAS 80FTE IN A SINGLE STATE DELIVERING OOH CARE BUT CANNOT GET WIDESPREAD INSURER FUNDING, DESPITE DELIVERING CARE TO THOUSANDS OF PATIENTS AT HOME DURING COVID.

A default benefit for the provision of hospital in the home and hospital substitutive services (including Type C procedures) would assist all providers in establishing care paths for consumers that are not disrupted by funding idiosyncrasies and regulatory barriers.

Question 29 – What more could/should default benefit arrangements do to support equitable access to privately insured services, or are there more appropriate arrangements to promote equity?

Minimum default benefits should be extended to include Type C procedures. A floor price for Type C services is required as most of these services (such as infusions) are not provided in other settings. Public hospitals are funded for these services under IHACPA calculated Tier 2 arrangements however no such funding

framework exists for private consumers who are therefore significantly disadvantaged under the current arrangements.

It needs to be made clear that Band 1 same day accommodation applies to full and half day rehab and mental health equivalent benefits. In CHA members' experience, PHIs often refuse to fund these services under minimum benefits despite second tier calculation for these services.

Nursing Home Type Patient (NHTP) rules and their application to mental health, rehab and palliative care also needs clarification. Under the Benefit Requirement Rules, Acute Care certification should not be required for sub-acute services (such as mental health, rehab and palliative care), and NHTP rates should not apply in these settings.

Question 32 – In calculating the average charge for the equivalent episode of hospital treatment for second-tier default benefits, what are your thoughts on taking a volume-weighted approach?

CHA is very supportive of this suggestion. The current methodology is easily manipulated while this proposed methodology would improve accuracy by using only contracted rates at their usage level.

Question 33 – Second-tier benefit hospital categories

Regarding hospital classification for second tier purposes, CHA suggests hospitals which are licensed together (such as health campuses) are able to have more than 1 AIHW peer group (and therefore second tier classification) allocated to them. This has started to become an issue when an amalgamated parent hospital with a satellite campus hospital is, for the purposes of second tier classification, only assigned a single group. In these instances the single grouping may not accurately reflect the services delivered at both sites, but current rules do not allow an alternative.

There should be clarity/direction given on the expected second tier calculation when there are few analogous hospitals. Specifically, health insurers often state they do not have enough similar hospitals to generate a second tier rate. In these instances, clear rules are required such as if there are less than five hospitals of that type in a region, the second tier calculation is performed at the State level. If there are still less than five hospitals of that type at a State level, the second tier calculation is performed at the national level.

Question 36 – Improving administrative efficiency

As mentioned above, there are significant efficiencies to be made from standardising excessive safety and quality clauses, and CHA is supportive of further investigation into possible efficiencies could be realised from further prescribed contract templates.

Another simple and significant administrative efficiency would be realised by extending second tier status to all accredited hospitals. As the Paper notes, there is not much difference in application criteria, and any extra requirements could be added to the accreditation process. This would remove the administrative burden for the Department who must manage the process and keep the list up to date, and the administrative burden and application cost for hospitals. This would also give the Commonwealth a mechanism for ensuring non-contracted hospitals meet a higher standard.

To alleviate the administrative cost to private health insurers of creating the many second tier benefit schedules, another possibility would be that the Department uses HCP data to calculate a single, casemix-based schedule of second tier benefits. Such a schedule would need to be updated annually.

Question 38 – Future options under consideration

The Paper offers options for reform of default benefits arrangements. The table below outlines the viability of each option and commentary on how it could be implemented, with the viability considerations being patient access, minimised out of pocket costs and quality of care.

Option	Outline	Viable	Commentary
Option 0	Maintain status quo	Yes	As outlined above, there are improvements that can be made to default benefit arrangements to the benefit of patients. However, where reforms with poor evidence are also being considered, maintaining the status quo is the safer option.
Option 1	Abolish default benefits	No	This option would lead to significant increases in out of pocket costs, reduced patient access and choice, would impact hospital viability, and would increase public hospital workloads. It is clear from the Paper that further impacts are poorly understood.
Option 2	Retain benefits but target them specifically	No	Not enough information is available to countenance this option. Further, it appears to be based on the false notion that only hospitals and patients actually receiving second tier rates benefit from them. This avenue also removes the option for all private hospitals to benefit from positive reforms to default benefit arrangements.
Option 3	Amend legislation to reduce ambiguity and focus policy aims	Maybe	There is insufficient information available on the types of changes that would be considered. This option would require extensive work on the part of hospitals to ensure that the role of default benefits is appropriately expanded to the benefit of patient care and access.
Option 4	Simplify default benefits	Maybe	As with option 3, insufficient information is available to understand if this would be a net-benefit patients. CHA suggests further work is done on the merits of moving to a weighted national efficient price for the private sector.
Of the options for change, CHA supports combining them to improve default benefit arrangements in the short term (as outlined throughout this document) while working towards a longer-term overhaul and simplification of private health sector funding arrangements overall, specifically through a Private Weighted Activity Unit and Private National Efficient Price.			