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Reforming default hospital benefits

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Second-tier default benefits

Second-tier default benefits provide patients treated in an eligible hospital, that does not have a negotiated agreement with the patient's insurer, access to higher benefits than those that would otherwise be payable.[1]

The second-tier default benefit was introduced in 1998 as a market intervention to assist with direct negotiations between health funds and hospital providers. At the time, individual health funds had a larger average market share than operators in a fragmented private hospital market. By placing an effective floor under provider payments, the benefit would even up negotiations for 'second-tier' smaller hospitals.

By 2003, private hospital ownership was concentrating and negotiating power was levelling. After five years' negotiations, the health fund-provider contracting environment had matured. As well, health funds wanted to enter contracts with private hospital networks so that their members could access those services. A government proposal to remove the second-tier default provision was defeated by industry group argument that its removal may reduce consumer choice of hospital providers.

However, the current operation of second-tier default benefits is simply a hospital subsidy program, and a poor one. It does little to ensure consumers have access to hospital care where they live. It also can support very poor care, such as some cosmetic surgery clinics.

Second-tier default benefits are the major barrier to promoting out of hospital care in Australia. While funds are required to pay minimum benefits for non-contracted hospitals, innovation is stifled and the market mechanisms that should promote out of hospital care are retarded.

In a post-COVID environment, Australians cannot afford to be propping up old models of care. We also cannot afford a poorly targeted hospital subsidy program which in many cases reduces consumers' access to health care.

Consumer impacts

Reforming second tier default benefits as recommended will:

- Reduce out of pocket costs for consumers
- Remove a major barrier to out of hospital care
- Reduce pressure on premiums, and
- Improve the distribution of services over time by removing disincentives for rural services

Current winners and losers

The second-tier default benefit is a regulatory price control. When governments control prices, "serious welfare loss results because not enough of the good is sold. The wasted chance to create both producer and consumer surplus from those sales is known as 'deadweight loss' because it is income that is lost forever. In addition to creating deadweight loss, an artificially high price transfers profits from consumers to producers." [2]

The second-tier default benefit is a partial price control, because it allows for sensible contractual arrangements between most providers and health funds while providing a safety net for providers who do not have contractual agreements. Thus, the second-tier default benefit transfers gains towards:

- **Low quality provider hospitals**. Hospitals that provide low quality services that cannot attract a contract from health funds due to quality issues are able to attract 85% of the average price regardless of quality.
- **Providers in oversupplied areas.** Hospitals in areas of high competition, such as inner urban areas, can attract 85% of the average price regardless of the level of competition.

Second-tier default benefits mean gains are transferred away from:

- **Consumers (and health funds).** Consumers pay more than the market price for services that are not valued enough by their representative health funds to attract a contractual arrangement.
- **High quality provider hospitals.** As the health funds must account for paying benefits for lesser-value services through the second-tier default benefits, they are unable to offer higher (deserved) benefits to quality providers.
- **Providers in undersupplied areas.** As the health funds must account for paying benefits for lesser-value services in oversupplied markets through the second-tier default benefits, they are unable to offer higher benefits to providers in undersupplied areas.
- **Providers in higher-cost locations**. Some areas have higher costs of labour, transport or other inputs. Remote locations, even large urban centres, can often have higher supply costs. As the health funds must account for paying benefits for lesser-value services in oversupplied markets through the second-tier default benefits, they are unable to offer higher benefits to providers in undersupplied areas.
- **Providers offering innovative services, such as hospital in the home**. Innovative services generally require greater risk tolerance from both the provider and the funder. As the health funds must account for paying benefits for lesser-value services in oversupplied markets through the second-tier default benefits, their risk tolerance is reduced and more innovative services need to demonstrate a higher return ratio.
- **Taxpayers**. The administrative load in the current system is significant and, in most cases, unnecessary. This produces a burden on taxpayers for no net community gain.

There are strong incentives under the current system to provide a low-cost service in an oversupplied area, as receiving a large percentage of the average fee with no need to improve quality or service levels is a very attractive business proposition. The information asymmetry often observed in health care (where consumers may not be in a position to judge the quality of the

product) aids such providers.[3] Supplier-induced demand, where consumers are supplied more health care than may be optimal, has been observed in a number of studies in Australia and overseas. [4] [5]

In addition, capital investment decisions are distorted, meaning that construction and capital maintenance is wrongly favoured in oversupplied urban locations, and capital is transferred from undersupplied areas such as rural and regional Australia.

Evidence

Second-tier default benefits are predominantly used by day hospitals in urban areas.

In 2018-19, there were 249,607 insured patients treated in hospitals without an agreement. Around 72% of these separations without an agreement occur in day hospitals.[6]

Very few day hospitals are located in rural and remote areas. An examination of the list of the 345 day hospitals eligible for second-tier default benefits in January 2020 suggests that only around 10% are outside major cities. [7]

There has been a decline in patients with private health insurance treated in hospitals without an agreement over recent years.[8] Generally, hospitals have entered agreements with health funds to reduce out of pocket costs for their customers. However, day hospitals are not (on average) moving with this trend. Day hospitals charge patients significantly higher out of pocket hospital fees than other private hospitals. In 2018-19, the average hospital gap payment across all separations per day in day hospitals was $134, [9] compared to $63 per day for other private hospitals.[10] This gap has increased over the last five years by $24 for day hospitals and by $9 for other hospitals. [11]

Private Healthcare Australia data for 2018-19 (based on 64% completeness) suggests that around 2.2% of second-tier default benefits are paid in rural areas, and a further 11% in large regional centres.[12]

Policy proposal

Second-tier default benefits are not meeting their intended purpose of supporting smaller hospitals and hospitals in underserviced areas. PHA recommends the Australian Government modernise second-tier default benefits and realign the policy to the original intent.

- Reduce out of pocket costs
    - Require hospitals using default benefits to sign a common form of undertaking to prohibit charging more than 100% of the defined benefits, should a hospital fall out of contract.
- Change the benefits
    - Option one: abolish second-tier default benefits
    - Option two: abolish second-tier default benefits in urban areas
    - Option three: decrease second-tier default benefits in urban areas and increase second-tier default benefits in rural areas
- For options two and three, replace the current formula with defined benefits

Reduce out of pocket costs: a common form of undertaking

The existing second-tier default benefit is a floor price, but there is no ceiling. With most services now contracted between insurers and hospitals, services attracting second-tier default benefits have some of the largest out of pocket costs in the nation. It is unfair to consumers, health funds and contracting hospitals that non-contracting hospitals have a high floor price with no limits on what they are able to charge the consumer.

Private Healthcare Australia recommends that to access second-tier default benefits, providers be required to sign a common form of undertaking which stipulates that services receiving default benefits be prohibited from charging more than 100% of the reference price. There is a precedent; prior to 2015, Medicare only paid benefits for services provided by 'participating' optometrists who have signed a Common Form of Undertaking for Participating Optometrists with the Australian Government. The optometry Common Form of Undertaking required that optometrists charge no more than the Medicare Benefits Schedule standard fee.

Change the benefits

Second-tier default benefits were originally designed to assist smaller and regional services. The current policy settings do not achieve these goals. There are four options to be considered.

Option one: abolish second-tier default benefits

Second-tier default benefits are a dated, poor policy prescription that is not meeting the policy objectives. The best option would be to abolish them.

Option two: restrict second-tier default benefits to rural and remote area hospitals and increase the rate

Should option one be rejected, PHA recommends the second-tier default benefit be abolished for all services in Rural, Remote and Metropolitan Area (RRMA) classifications 1-3 (urban areas).

PHA recommends that any default benefit rate for country hospitals be increased to 90% for services in RRMA 4-7 (rural and remote areas), unless the service was part of a larger entity with more than 3% national market share.

This would return the policy to the original intent, to protect and preserve private hospital services in rural and remote areas of Australia. Only having the benefit available in rural areas would promote greater levels of service in country Australia, as country-based services would be able to afford higher wages to attract better staff.

There is also a case for specialised hospitals in urban areas to attract default benefit rates if they can demonstrate to the Department of Health that they are providing a service otherwise unavailable in the location. Any default benefits should only be attracted for the new services, which may be a proportion of the new hospitals' services.

Option three: rebalance the benefits to promote rural and remote area hospitals.

Should options one and two be rejected, PHA recommends that the second-tier default benefit rate be set at 60% for all existing services in Rural, Remote and Metropolitan Area (RRMA) classifications 1-3 (urban areas) from 2021, and reduce by 10 percentage points each year until being abolished in 2026. No new services would be eligible for second tier default benefits.

Under this option, PHA recommends that the second-tier default benefit rate reference price be increased to 90% for services in RRMA 4-7 (rural and remote areas), unless the service was part of a larger entity with more than 3% national market share.

This would partially return the policy to the original intent, to protect and preserve private hospital services in rural and remote areas of Australia. The different rates between city and country services would also partially promote greater levels of service in country Australia, as country-based services would be able to afford higher wages to attract better staff.

Replace the benefit formula with defined benefits

The second-tier default benefit for hospital treatment is set at 85% of the average charge for the equivalent treatment, under that insurer's negotiated agreements for comparable private hospitals (those in the same state and in the same second-tier hospital category).

This approach increases incentives for hospitals to rely on default benefits, as they know that if hospitals and hospital groups increase the value of their contracts, the uncontracted hospital also receives a benefit. Freeloading on others' hard work reduces incentives to seek contracts that may suit consumers' needs.

The formula also allows for a farcical situation where uncontracted hospitals may receive higher benefits than contracted hospitals, depending on the changes to contracts elsewhere, the hospital location, and what stage of the contract cycle other hospitals are in.

A more sensible approach should default benefits be retained is a simple dollar rate. The defined benefit reference rate should be the same rate as for private patients in public hospitals, with default benefits being a proportion of the reference rate.

Implementation

The legislative framework underpinning second-tier arrangements is:

- The *Private Health Insurance Act 2007- Sections 121-8A to 121-8D*
- The *Private Health Insurance (Benefit Requirements) Rules 2011- Schedule 5*
- The *Private Health Insurance (Health Insurance Business) Rules 2018 - Part 2A.*

PHA's initial assessment suggests that changes to the Act are not necessary to implement the policy proposal. There would need to be changes to the *Private Health Insurance (Benefit Requirements) Rules 2011* at schedule 5(3) to:

- Option one
    - remove the clauses to abolish the second-tier default benefit, or
- Options two and three
    - nominate the new rates at clause 3(4) based on RRMA postcode on the location of service delivery
- insert a new clause based on the previous s23A of the *Health Insurance Act 1973* to provide for the common form of undertaking with providers

PHA's preliminary assessment suggests that the only change necessary to the *Private Health Insurance (Health Insurance Business) Rules 2018 - Part 2A* would be to reference the common form of undertaking as a requirement for the assessment criteria at clause 7C.

There would be a net reduction in legislation, consistent with government policy objectives to remove red tape.

Conclusion

Australians want private health to be high quality and accessible, with minimal out of pocket costs and low insurance premiums. The previous government began a series of reform initiatives to address these aims, and reforming default benefits is a key step identified in the program.

Removing or reforming second-tier default benefits will increase access to care by removing incentives to provide care in already overserviced areas with old-fashioned inpatient models. Without the regulatory crutches, hospitals and other health providers are more likely to promote modern community-based models of care, in areas where services are most needed.

The current practice of some providers in charging very high out of pocket costs, while collecting the second-tier default benefits, will be reduced with the proposal that in exchange for the right to receive default benefits comes the responsibility not to profiteer.

Choice will be protected by other elements of the system, in particular the ability of consumers to switch funds with minimal fuss. More importantly, health funds want to provide choice and care to their customers, because that is what consumers demand.

Endnotes

[1] Department of Health 2019. 'Second-tier default benefits.' Updated 3 December 2019. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/private-second-tier.
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[10] Department of Health 2020. *Hospital Casemix Protocol Annual Report 2018-19*, Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports. The other private hospital figure was derived by dividing the average charge by the average length of day.
[11] Department of Health 2020. *Hospital Casemix Protocol Annual Report 2018-19*, Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports.
[12] Data from Private Healthcare Australia, unpublished.