

Second Tier Default Benefits

This fact sheet provided by Day Hospitals Australia is part of a series of five fact sheets covering the following topics as relevant to day hospitals:

- **Second Tier Default Benefits**
- **Gold/Silver/Bronze/Basic categories of private health insurance covering hospital treatment**
- **Standardisation of clinical categories under private health insurance tiers**
- **Changed powers of the Private Health Insurance Ombudsman**
- **Changes to Prostheses Benefits for Medical Devices**

1 Executive Summary

Day Hospitals that wish to receive Second Tier Default Benefits where they do not have a negotiated agreement with a private health insurer need to be declared to be members of a class of hospital entitled to such benefits. This can be in continuation of their status as at 31 December 2018, or following successful application or re-application to the Department of Health (**Department**).

All private hospitals have been classified by the Minister to be within a certain group of hospitals for the purpose of calculation of Second Tier Default Benefits.

The Minister must approve the application for inclusion in this class where the private hospital pays the application fee of \$850 currently and meets the eligibility criteria of:

- being a private hospital that is accredited as meeting NSQHS Standards;
- not billing patients directly for the minimum benefit payable by the patient's insurer;
- making provision for informed financial consent; and
- submitting Hospital Casemix Protocol Data to health insurers electronically with every claim for second-tier default benefits.

The inclusion in the relevant class will be granted for a timeframe to align with a hospital's NSQHS accreditation.

Private health insurers are required to calculate and audit their applicable Second Tier Default Benefits by class of hospital and state, and notify such applicable benefits to the Department and affected hospitals within specific timeframes.

Day Hospitals should do the following:

- Hospitals should review whether they were approved to receive Second Tier Default Benefits as at 31 December 2018. If this is the case, they will continue to be eligible to receive them until that approval expires. If the eligibility expiry date occurs 12 months or less before the expiry of the hospital's accreditation through the National Safety and Quality Health Service Standards (**NSQHS Standards**), the hospital remains eligible for Second Tier Default Benefits until 60 calendar days after the day on which the then-current accreditation expires. Either way, hospital staff should make provisions (eg by diarising dates as appropriate) for re-application to be submitted at the appropriate time to avoid losing eligibility, in view of the timeframe for the decision about the re-application being 60 days. They should also familiarise themselves with the documentation that will be required for the re-application.

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- If a hospital was not eligible at 31 December 2018 and wishes to become eligible, it will need to apply following the process below, providing appropriate evidence to demonstrate it is meeting the eligibility criteria as detailed in the Department of Health's *Private Health Insurance Second-tier Default Benefits Guidelines (Guidelines)*.
- Hospitals that are eligible for such benefits have an ongoing disclosure obligation to the Department where they cease to meet any eligibility criteria for Second Tier Default Benefits.
- Where hospitals receive notice of being categorised in a certain way for the purpose of the assessment of Second Tier Default Benefits, they should review if this is accurate, and seek review within 28 days as set out below if this is not the case.

2 Background

Under the *Private Health Insurance Act 2007* (Cth) (**PHI Act**), the second tier default benefit (**Second Tier Default Benefit**) is the minimum benefit paid or payable by a health fund for hospital treatment provided by an eligible private hospital which does not have a negotiated agreement with the fund. Recent changes to the private health insurance regulatory framework change the way that hospitals become eligible to receive Second Tier Default Benefits, and to some extent the way that Second Tier Default Benefits are calculated. The changes to the eligibility assessment process came into force on 1 January 2019. Insurers must apply the changed calculation of Second Tier Default Benefits commencing no later than 31 August 2019.

Changes to the PHI Act and subordinate legislation through the *Private Health Insurance Legislation Amendment Act 2018* (**Amending Act**) and *Private Health Insurance (Reforms) Amendment Rules 2018* (Cth) (**Amending Rules**) provide for approval by the Minister (as administered by the Department) of a hospital as a member of a class of hospitals entitled to receive Second Tier Default Benefits, and for a slightly amended calculation of such benefits by insurers.

Prior to the changes coming into force on 1 January 2019, hospitals' eligibility to receive Second Tier Default Benefits was determined by the industry-based Second Tier Advisory Committee (**STAC**). The Amending Act amended the PHI Act by inserting new sections 121-8 to 121-8D, which now provide that a hospital may apply to the Minister to become eligible for Second Tier Default Benefits. The application will be assessed according to criteria as set out under the *Private Health Insurance (Health Insurance Business) Rules 2018* (**Business Rules**). If granted, the application will result in the hospital being entitled to receive Second Tier Default Benefits, calculated in accordance with the amended *Benefit Requirements Rules 2011* (Cth) (**Benefit Requirements Rules**).

3 Approved hospitals as at 31 December 2018 remain eligible

Hospitals that were included in the list of second-tier eligible facilities as previously approved by STAC on 31 December 2018, and therefore immediately prior to the changes coming into force on 1 January 2019, will continue to be eligible until such eligibility expires.

However, if the eligibility expiry date occurs 12 months or less before the expiry of the hospital's accreditation through the NSQHS Standards, under the Benefit Requirements Rules (rule 7E), the hospital remains eligible for Second Tier Default Benefits until 60 calendar days after the day on which the then-current accreditation expires. The hospital will then need to re-apply as detailed below.

4 Application process

A hospital may apply to the Minister for inclusion in the class of hospitals that are eligible to receive Second Tier Default Benefits under section 121-8 of the PHI Act, following payment of such a fee as set out in the Business Rules (\$850 as at 12 April 2019), and in the prescribed form. The Department provides further guidance about

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the application process, including details of acceptable documentation and an overview flowchart, in its Guidelines.

Where the Department requests additional information in relation to an application, the expectations as indicated in the Guidelines is that such information is provided within 5 days.

The Minister must provide an answer granting or rejecting the application within 60 days under s 121-8A of the PHI Act. Hospitals should apply or re-apply at the appropriate times to ensure that they do not lose eligibility prior to receiving notice of the outcome of a re-application.

If the hospital satisfies the eligibility criteria as set out below, the Minister must include the hospital in the class of hospitals eligible to receive Second Tier Default Benefits, and provide the Hospital with written notice of this inclusion. This notice must include the hospital's eligibility expiry date.

If the hospital does not meet the criteria, the Minister must provide written notice of this, including reasons why the criteria are not met. Such a decision is reviewable by the Administrative Appeals Tribunal under section 328-5 of the PHI Act. The Guidelines indicate that where the Department expects an application to not be successful, it will provide the hospital with an opportunity to respond prior to making a formal decision.

5 Eligibility criteria

To be included in the second-tier eligible hospitals class, a hospital must meet all of the following requirements as set out in the Business Rules, rule 7C:

- be a private hospital;
- be accredited against the NSQHS Standards by an approved accreditation agency at the time of application;
- not bill patients directly for the minimum benefit payable by the patient's insurer;
- make provision for informed financial consent; and
- submit Hospital Casemix Protocol Data to health insurers electronically with every claim for second-tier Second Tier Default Benefits.

Informed financial consent

These requirements are the same as those previously applied by STAC. As detailed in the Business Rules (rule 3 - Definitions), making provisions for informed financial consent means the hospital:

has procedures in place to inform a patient or nominee, in writing, of what hospital charges, insurer benefits and out-of-pocket costs (where applicable) are expected in respect of the hospital treatment. A patient or nominee must be informed

- for scheduled admissions—at the earliest opportunity before admission for the hospital treatment; or
- for unplanned admissions—as soon after the admission as the circumstances reasonably permit.

Because this requirement is included in the second edition of the NSQHS Standards applying from 1 January 2019, hospitals accredited or re-accredited after this date will not need to provide separate evidence in relation to this criterion with their application or re-application. Other hospitals will need to provide appropriate evidence as referred to in the Guidelines (page 5).

Notice of change

Where an approved hospital ceases to meet any of the eligibility criteria for whatever reason, it must provide written notice to the Department as soon as practicable, as required under the Business Rules, rule 7D.

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Section 121-8C of the PHI Act provides that the Minister may revoke the inclusion of a hospital in the class of hospitals eligible for Second Tier Default Benefits if the Minister considers that the hospital ceases to satisfy the eligibility criteria. Such a decision is included in the decisions under the PHI Act that are reviewable by the Administrative Appeals Tribunal under section 328-5.

6 Timeframe for eligibility expiry

Where an application is successful, hospitals will be eligible for Second Tier Default Benefits for a period that is based on their NSQHS accreditation. Inclusion in the relevant class will be granted for a period ending 60 calendar days after the day on which the hospital's current accreditation under the NSQHS Standards expires (Guidelines page 8). This alignment is intended to allow hospitals sufficient time to re-apply as soon as they have achieved re-accreditation, to receive a decision on the application prior to eligibility lapsing.

7 Classes of hospitals

The calculation of Second Tier Default Benefits is based on a categorisation of hospitals, taking into account their size by bed number, and the type of services that they provide. Specific categories are set out under the Benefit Requirements Rules, Schedule 5, clause 1A(7). The categories remain mostly unchanged from the categories that existed previously, but are now assigned by the Department.

Day hospitals are expected to mostly fall into the (slightly amended) category (g), "*private hospitals that provide episodes of hospital treatment only for periods of not more than 24 hours*".

Categories assigned by Department

The Department provides a list indicating the relevant category for each private hospital that has been declared under the PHI Act on its website. However, such a categorisation by itself does not indicate that a hospital is thereby eligible for Second Tier Default Benefits.

As affirmed in the Guidelines, the categorisation for each private hospital will be renewed annually by the Department through a process of assessment and consultation. Consultation is intended to occur in May of each year, with a list of hospitals and relevant categories published on 1 June. Hospitals will be able to seek an internal review of a categorisation decision within 28 days of being notified of such a decision, as set out in the Benefit Requirements Rules, Schedule 5, clause 1B.

8 Calculation of Second Tier Default Benefits

Second Tier Default Benefits in accordance with Schedule 5 of the Benefit Requirements Rules must be provided by a private health fund in relation to treatment by a second-tier eligible hospital where no negotiated agreement exists between the fund and the hospital.

For each episode of treatment, Second Tier Default Benefits apply as at the day of admission (Guidelines, page 9).

The Second Tier Default Benefit payable by an insurer for an episode of treatment at a second-tier eligible hospital under section 3(4) of Schedule 5 remains 85% of the "*average charge for the equivalent episode of hospital treatment*" under the insurer's negotiated agreement in force as at 1 August of the relevant year, with hospitals in the same category in the same state (with the ACT taken to be part of NSW, and the NT taken to be part of SA for this purpose). If there are fewer than five such negotiated agreements in force at the time of calculation, all agreements regardless of hospital category will be included per subsection 3(8).

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The formula

The formula for calculation of the “average charge for the equivalent episode of hospital treatment” under section 3(5) of Schedule 5 is unchanged, and is provided in the Appendix for quick reference.

Such a charge for the calculation of the benefits under section 3(7) includes any access or co-payment paid by private health insurance members in accordance with the fund rules of the particular health insurance fund.

Also, where the Second Tier Default Benefit calculated in accordance with clause 3 of Schedule 5 is lower than the “basic default benefit” set out in Schedules 1, 2 or 3 of the Benefit Requirements Rules, the minimum benefit is still the higher “basic default benefit” under Schedule 1, 2 or 3 as applicable.

Change in basis for calculation

The main change in the basis for the calculation is that insurers must base it on the categories of both the receiving hospital and the comparable hospitals as assigned by the Department, and the negotiated agreements in force, both as at 1 August of the relevant year.

The Guidelines also require that insurers must provide lists of their applicable Second Tier Default Benefits for the year commencing on 1 September to the Department by 31 August of that year. In addition, they must have these lists independently audited for compliance with the requirements under Schedule 5, in accordance with Australian auditing standards, and must provide audit reports including a copy of the list Second Tier Default Benefits and a statement attesting to its correctness to the Department no later than 30 September. Where the audit identifies any necessary changes to the provided list of benefits, this must also be advised to the Department, and any affected hospitals.

9 Calculation during transition period

Insurers are not required to re-calculate their Second Tier Default Benefit rates between 1 January 2019 and 1 August 2019. From 1 August 2019 forward, Second Tier Default Benefits must be calculated based on the amended Benefit Requirements Rules as detailed above.

However, for any admissions on or after 1 January 2019, Second Tier Default Benefits as calculated to apply prior to 1 January 2019 must be paid to eligible hospitals on the basis of the category that the hospital falls under as of 1 January 2019, as assigned by the Department.

10 Change of hospital status or category

Where a hospital ceases to be eligible for Second Tier Default Benefits, such benefits must still be paid in relation to any hospital treatment that was already scheduled when the hospital ceased to be eligible, or where the patient was admitted while the hospital was still eligible (Benefit Requirements Rules, Schedule 5, rule 3(3)).

11 Questions and complaints in relation to Second Tier Default Benefits

- Questions to the Department in relation to Second Tier Default Benefits should be addressed to PHIsecondtier@health.gov.au.
- The Private Health Insurance Ombudsman may be able to assist in relation to Second Tier Default Benefit-related matters between hospitals and private health insurers where they relate to the rights of consumers (<http://www.ombudsman.gov.au/How-we-can-help/private-health-insurance>).
- See also fact sheet **Changes to powers of Private Health Insurance Ombudsman** in this series.

Resources from the Department of Health

Relevant for day hospitals and other healthcare providers

- Department of Health, *Private Health Insurance Second-tier Default Benefits Guidelines* (11 December 2018), available at:
[http://www.health.gov.au/internet/main/publishing.nsf/Content/5854E2DDCCA1D2F8CA2583400018B8D9/\\$File/Guidelines-Second-tier-Default-Benefits.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/5854E2DDCCA1D2F8CA2583400018B8D9/$File/Guidelines-Second-tier-Default-Benefits.pdf)
- Department of Health Second Tier Default Benefit resource page, including *Application to become a second-tier eligible hospital*, available at:
<http://www.health.gov.au/internet/main/publishing.nsf/Content/private-second-tier>
- Department of Health list of Declared Hospitals, available at:
<http://www.health.gov.au/internet/main/publishing.nsf/Content/hospitals2.htm#declared-hospitals>
- Department of Health short fact sheets (one page) relating to PHI reforms, addressing Second Tier Default Benefit framework
 - *Private Health Insurance Reforms – Second Tier Administrative Reforms*, available at:
[http://www.health.gov.au/internet/main/publishing.nsf/Content/F8FB399400D7A8C4CA2581BB007EA5EC/\\$File/Second%20tier%20administrative%20reforms.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F8FB399400D7A8C4CA2581BB007EA5EC/$File/Second%20tier%20administrative%20reforms.pdf)
 - *Private Health Insurance Reforms – Support for Private Hospitals*, available at:
[http://www.health.gov.au/internet/main/publishing.nsf/Content/F8FB399400D7A8C4CA2581BB007EA5EC/\\$File/Second%20tier%20administrative%20reforms.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F8FB399400D7A8C4CA2581BB007EA5EC/$File/Second%20tier%20administrative%20reforms.pdf)
- Department of Health FAQ Compilation in relation to *Private Health Insurance (Reforms) Amendment Rules 2018* (Cth). These FAQs should be read in conjunction with the Amendment Rules, and the Explanatory Statement to the Amendment Rules. Second Tier Default Benefits are addressed on pages 23-24.
 - Department of Health, *Private Health Insurance (Reforms) Amendment Rules 2018 Frequently Asked Questions (FAQs)*, available at:
<http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reform-rules-2018>

For the general public

- The Department of Health has compiled a short (two pages) general fact sheet on the changes to private health insurance regulation. This fact sheet is also available in community languages other than English (simplified Chinese, traditional Chinese, Arabic, Vietnamese and Korean).
 - Australian Government, *Making private health insurance simpler for everyone*, available at:
<https://beta.health.gov.au/resources/publications/making-private-health-insurance-simpler-for-everyone-fact-sheet>

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Appendix

The formula for calculation of the “average charge for the equivalent episode of hospital treatment” under section 3(5) of Schedule 5 of the Benefit Requirements Rules is set out below:

The formula for calculating the average charge for the equivalent episode of hospital treatment by an insurer in each State is as follows:

$$R_j = \frac{\sum_{i=1}^n R_{ji}}{n}$$

Where:

j = group of equivalent episodes of hospital treatment under the insurer's negotiated agreements;

i = group of the insurer's negotiated agreements in force on 1 August of the first year with comparable private hospitals in the State;

n = the number of the insurer's negotiated agreements in force on 1 August of the first year with comparable private hospitals in the State;

R_{ji} = charge for episode of hospital treatment type j in the negotiated agreement i

R_j = average charge for episode of hospital treatment type j.

Contact

General information about Day Hospitals Australia (**DHA**), including about membership, can be found at <https://www.dayhospitalsaustralia.net.au/>.

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