Q&A Second Tier Default Benefits

What is the second tier default benefit?
It is safety net for facilities that can demonstrate compliance with a range of quality and service criteria if they do not have a contract in place with a health fund.

What are second tier rates?
Second tier rates are essentially based on 85% of the average rate for a particular service as reflected in each fund's contract. The rates are State-based and also vary according to seven different categories of facility based on size, services and complexity.

How do I obtain a second tier default benefit schedule from a health fund?
Health funds are only required to provide their second tier schedules to hospitals once they are deemed eligible for second tier and are off-contract with that fund. APHA has no access to second tier schedules.

What is the STAC?
STAC stands for Second Tier Advisory Committee, which meets every three months to consider applications for second tier eligibility. The Committee comprises 3 nominees of private hospitals and 3 nominees of health insurers and is bound by the Administrative Arrangements for the Second Tier Default Benefits for Overnight and Day Only Treatment

How do I apply for second tier default benefits?
Details of how to apply, and a sample application to follow as a guide, are available under the Industry Resources area of the APHA website at www.apha.org.au. All applications must be submitted via the second tier portal at www.stacapplications.org.au

Why wasn't I reminded that my facility's Second Tier Default Benefits approval was expiring on 30 June?
Reminders are sent in one of two ways:

1. The Department of Health publishes a PHI circular in late March, included is a list of all the facilities whose approval to receive Second Tier Default Benefits is due to expire on 30 June; and

2. APHA members are kept up to date with Member Bulletins (Vital Signs) and direct emails advising them of the need to re-apply.

How do I receive notification of Private Health Insurance (PHI) Circulars?
Email PHI@health.gov.au with the following details: nature of business, company name, contact name, position, postal address, phone, fax and email address and request to be added to the email distribution list.

Can I get the Committee to consider our application out-of-session?
There is no capacity or precedent for an out-of-session consideration of applications. You will need to re-apply to the next scheduled meeting of the Second Tier Advisory Committee (STAC).

When do I need to re-apply?
If your second tier eligibility is expiring on 30 June 2018 you should re-apply to the May 2018 STAC meeting. STAC meeting dates and cut-off dates for applications to be received are made available on the APHA website http://www.apha.org.au/resource/2nd-tier-default-benefit-eligibility/

I have my previous approval for Second Tier Default Benefits letter but it doesn't list the expiry date?
A facility's approval for Second Tier Default Benefits expires at the end of the following financial year from the date that their approval takes effect. The date of effect is not known at the time your facility's letter of approval is sent as this is managed by the Department of Health after they receive the Second Tier Advisory Committee's recommendation of approved facilities. However, the date of expiry for each facility is included in the STAC approved list published by the Department.

When will my facility's approval come into effect?
We do not know the date of effect of the approved applications as this is managed by the Department of Health after they receive the Second Tier Advisory Committee's recommendation of approved facilities. New facilities will be eligible to receive STDB from the date of effect of the *Private Health Insurance (Benefit Requirement) Amendment Rules*, which refer to the Committee-approved list in which the new facility appears.

APHA is notified of the date of effect after the event, via the PHI Circular along with the rest of the health industry.

Who can I speak with at the Department of Health about second tier?
Private Health Insurance Branch
Department of Health
GPO Box 9848
Canberra ACT 2601
Email PHI@health.gov.au

Now that we have been approved for Second Tier default benefit, can you please advise what the next step is?
You need to request a second tier benefit schedule from each health fund with which you do not have a contract. This schedule lists what each fund will pay for one of their members under second tier arrangements. The hospital can accept the second tier benefit as full payment or it can charge a patient co-payment provided informed financial consent is obtained.

What do we do if health funds won't give us their second tier banding schedule?
If you are having a problem with any fund you could take it up with the Department of Health.

Do you know where we find the schedule that outlines the banding number allocated to/associated with every procedure?
APHA compiles and distributes the National Procedure Banding Schedule (NPBS) which classifies the Medicare Benefits Schedule (MBS) items into theatre bands. It is an essential tool for every private hospital and day surgery centre. If you wish to subscribe send an email to info@apha.org.au

Does second tier status remain with the facility after change of ownership?
Second tier eligibility attaches to the facility/provider number so eligibility remains with a change in ownership (unless a new licence/provider number is required). You may need to advise the State Health Department in relation to your licence and may also need to change the hospital declaration with the Commonwealth Department. Further information is available at http://www.health.gov.au/internet/main/publishing.nsf/Content/hospitals2.htm

Are there any resources/information on standard Second Tier rates pricing with Private Health insurers? I understand that these are audited, but I can't find any documentation around this
The audit requirement is specified in part 6 of the admin arrangements: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-phicirculars2015-64-attc

Is there a difference between default rates and second tier rates?
In theory yes, as second tier rates are essentially based on 85% of the average contracted rate for a particular category of facility in a particular state. However, if a fund does not have any contracts with a particular category of facilities in a particular state, or their contracted rates for a particular type of procedure are very low, the second tier rates may be less than the basic default rates, in which case the basic default would be the applicable rate.

How do I find out what the default rate and the second tier rate is for a particular procedure?
For the basic default rate, refer to the Private Health Insurance (Benefit Requirement) Rules 2011 which can be found at; http://www.comlaw.gov.au/Details/F2015C00141 The second tier rate for each fund will be different. Funds are only required to provide their second tier schedule to hospitals when 1) the hospital has been granted second tier eligibility and 2) they do not have a contract with the health fund in question (i.e. there is no way to find out specific second tier rates ahead of time).

If your question is not answered above or you require further clarification please send an email to info@apha.org.au