EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health and Ageing

Private Health Insurance Act 2007

Private Health Insurance (Benefit Requirements) Rules 2007

Section 333-20 of the *Private Health Insurance Act 2007* (the Act) provides that the Minister may make *Private Health Insurance (Benefit Requirements) Rules* (the Rules) providing for matters required or permitted by Part 3-3 of the Act, or necessary or convenient in order to carry out or give effect to Part 3-3 of the Act.

As part of reforms to private health insurance announced by the Australian Government on 26 April 2006, regulation of private health insurance is moved from the *National Health Act 1953* (NHA) (and regulations under the NHA), into the new *Private Health Insurance Act 2007* (PHI) (and Private Health Insurance Rules made under the PHI).

These Rules provide for the minimum benefit requirements for psychiatric, rehabilitation and palliative care and other hospital treatment and were previously covered by provisions in Schedule 1 (1) (bj) of the *National Health Act 1953*.

Schedules 1 to 6 to these Rules set out the minimum levels of benefit which are payable for hospital treatment. Namely, benefits for overnight accommodation (Schedules 1 and 2), same day accommodation (Schedule 3), nursing-home type patients (Schedule 4), second-tier default benefits (Schedule 5), and outreach services (Schedule 6).

Private health insurers were extensively consulted and provided with opportunities to comment upon the new Private Health Insurance legislative package. Consultations were attended by representatives from individual private health insurers and peak industry bodies (the Australian Health Insurance Association and Health Insurance Restricted Membership Association members funds), private hospitals and their industry representatives (Australian Private Hospitals Association and Catholic Health Australia), the Australian Medical Association, other health care providers, the Private Health Insurance Administration Council, the Private Health Insurance Ombudsman, Consumers' Health Forum of Australia and central agencies. The Department also met with industry on an individual basis when requested. All of the industry representatives have expressed strong support for the proposed legislative framework including the Private Health Insurance Rules.

The Office of Best Practice Regulation has advised that no additional Regulation Impact Statement (RIS) is required. A RIS that was prepared for the Private Health Insurance Bill 2006 (PHI Bill) which analysed the options associated with the Australian Government's recent initiatives to improve the attractiveness of and participation in private health insurance for consumers. The measures include those under the *Private Health Insurance Act 2007* and associated legislative instruments.

The Act does not specify any conditions that need to be met before the power to make the Rules may be exercised.

Details of the Rules are set out in the Attachment.

The Rules are a legislative instrument for the purposes of the *Legislative Instruments Act 2003*.

The Rules commence at the same time as the Act commences if they are registered before the Act commences; or, if the Rules are registered on or after the Act commences, the Rules commence on the day they are registered.

Authority: Section 333-20 of the *Private Health Insurance Act 2007*

ATTACHMENT

DETAILS OF THE *PRIVATE HEALTH INSURANCE (BENEFIT REQUIREMENT) RULES 2007*

PART 1 - Preliminary

1. Name of Rules

Rule 1 provides that the title of the Rules is the *Private Health Insurance (Benefit Requirements) Rules 2007.*

2. Commencement

Rule 2 provides for the Rules to commence at the same time as the Act commences if they are registered before the Act commences; or, if the Rules are registered on or after the Act commences, the Rules commence on the day they are registered.

3. Definitions

Rule 3 defines specific terms used in the Rules.

PART 2 - Minimum benefit requirements

4. Psychiatric care, rehabilitation and palliative care

Subrule 4(1) provides that the benefit payable under a policy for any part of hospital treatment that is psychiatric care, rehabilitation or palliative care provided in a hospital with no medicare benefit payable for that part of the treatment, must be at least the amount set out, or worked out using the method set out, in Schedules 1, 2, 3, 5 or 6 for that type of treatment.

Subrule 4 (2) provides that despite sub-rule (1), the minimum benefit for the treatment may be reduced by the amount of any co-payment or excess that is required to be paid under the insured person's policy in respect of that treatment.

5. Other hospital treatments

Subrule 5 (1) provides that if a policy covers any type of hospital treatment provided in a hospital, other than treatment referred to in rule 4, being treatment specified in either of Schedules 1, 2, 3, 4, 5 or 6, it must provide at least the minimum benefit set out, or worked out using the method set out, in Schedules 1, 2, 3, 4, 5 or 6 for that type of hospital treatment.

Subrule 5 (2) provides that despite sub-rule (1), the minimum benefit for the treatment may be reduced by the amount of any co-payment or excess that is required to be paid under the insured person's policy in respect of that treatment.

Schedule 1 – Overnight accommodation: private hospitals in all States/Territories and shared ward accommodation at public hospitals in Victoria and Tasmania

Part 1 - General

1. Circumstances

Clause 1 provides that Schedule 1 applies, where a policy covers a type of hospital treatment, and the treatment is provided to a patient who is not a nursing-home type patient, and the treatment:

- is provided to a patient at a private hospital or as shared ward accommodation at a public hospital in Victoria or Tasmania; and
- is provided for the purpose of permitting the provision to the patient of hospital treatment that is:
  - (i) a Type A procedure; and
  - (ii) for a period that includes part of an overnight stay.

Type A procedures are procedures specified in clauses 3 to 9, Part 2, Schedule 1 of the Rules. A Type A procedure also includes a certified Type B procedure or a certified overnight Type C procedure: definition of 'Type A procedure' in Rule 3 of Part 1 of the Rules.

2. Minimum benefit

Clause 2 (1) provides that the minimum benefit for hospital treatment provided in the circumstances specified in this Schedule is the amount set out in Table 1, 2, or 3 in Schedule 1 for that hospital treatment (as applicable).

Clause 2 (2) provides that days forming part of a continuous period of hospitalisation are to be counted when counting the days referred to in the tables in Schedule 1. Tables 1, 2, and 3 in Schedule 1 all refer to numbers of days as part of the method of working out the minimum benefit payable per night.

Part 2 – Type A procedures

3. Interpretation

Clause 3 provides that a Type A procedure is a procedure specified in clauses 3 to 9, of this Part 2, Schedule 1 of the Rules, provided to a patient in one of the categories of patients in clauses 4 to 9, Part 2, Schedule 1 of the Rules.

4. Advanced surgical patient

Clause 4 (1) provides that in Schedule 1 the term ***advanced surgical patient*** has the meaning given by clause 4.

Clause 4 (2) provides the situations when a patient is to be taken to be an advanced surgical patient upon admission to a hospital.

Clause 4 (3) provides the item numbers in the MBS for the purpose of clause 4, but indicates that a listing in clause 4(3) only applies where an item has a fee in the MBS greater than $753.72.

5. Obstetric patient

Clause 5 (1) provides that in Schedule 1 the term ***obstetric patient*** has the meaning given by clause 5.

Clause 5 (2) provides the situations when a patient is taken to be an ***obstetric patient*** during an admission to a hospital.

Clause 5 (3) provides that the item numbers specified in clause 5 are the item numbers in the general medical services table.

6. Surgical patient

Clause 6 (1) provides that in Schedule 1 the term ***surgical patient*** has the meaning given by clause 6.

Clause 6 (2) provides the situations when a patient is taken to be a ***surgical patient*** during an admission to a hospital.

Clause 6 (3) provides the item numbers in the MBS for the purpose of clause 6, but indicates that a listing in clause 6(3) only applies where an item has a fee in the MBS within the range of $224.43 to $753.71.

7. Psychiatric patient

Clause 7 provides that in Schedule 1 the term ***psychiatric patient*** is deemed to be a patient admitted to a hospital for the purpose of undertaking a specific psychiatric treatment program, subject to approval by the insurer.

If a patient is receiving psychiatric treatment that is not under a specific psychiatric treatment program, the patient is taken to be in the category of ‘other patient’.

8. Rehabilitation patient

Clause 8 provides that in Schedule 1 the term ***rehabilitation patient*** is deemed to be a patient admitted to a hospital for the purpose of undertaking a specific rehabilitation treatment program, subject to approval by the insurer.

The Note in this clause provides that if a patient is receiving rehabilitation treatment that is not under a specific rehabilitation treatment program, the patient is taken to be in the category of ‘other patient’.

9. Other patient

Clause 9 provides that in Schedule 1 the term ***other patient*** is deemed to be a patient at a hospital who is receiving any treatment that involves part of an overnight stay at a hospital, who is not an advanced surgical patient, surgical patient, obstetric patient, psychiatric patient, or rehabilitation patient.

A patient receiving hospital treatment that is palliative care as described in item 1 of the table in subsection 72-1(2) of the Act is deemed to be in the category of ‘other patient’.

Part 3 - Certified Type B procedures and certified overnight Type C procedures

10. Certified Type B procedures

Clause 10 (1) provides that minimum benefits for overnight accommodation provided for in Schedule 1 are payable for patients receiving a Type B procedure only if certification under subclause 10 (2) is provided.

Clause 10 (2) provides the requirements which must be satisfied in order for a Type B procedure to receive certification for hospital treatment for a period that includes part of an overnight stay at a hospital.

Type B procedures are procedures specified in clauses 3 to 7 of Schedule 3.

11. Certified overnight Type C procedures

Clause 11 (1) provides that minimum benefits for overnight accommodation provided for in Schedule 1 are payable for patients receiving a certified Type C procedure only if certification under subclause 11 (2) is also provided.

Clause 11 (2) provides the requirements which must be satisfied for a certified Type C procedure to receive certification for hospital treatment for a period that includes part of an overnight stay at a hospital.

Type C procedures are procedures specified in clause 8 of Schedule 3. Certified Type C procedures are Type C procedures certified in accordance with clause 7 of Schedule 3.

Schedule 2 – Overnight accommodation: shared ward accommodation at public hospitals in the ACT, NSW, Northern Territory, Queensland, South Australia and Western Australia.

1. Circumstances

Clause 1 provides that Schedule 2 applies, where a policy covers a type of hospital treatment, and the treatment:

- is provided to a patient as shared ward accommodation at a public hospital in the ACT, NSW, Northern Territory, Queensland, South Australia, or Western Australia; and
- is provided to a patient who is not a nursing-home type patient; and
- is provided for the purpose of permitting the provision to the patient of hospital treatment that is:

(i) a Type A procedure; and
(ii) for a period that includes part of an overnight stay at a hospital.

Type A procedures are procedures specified in clauses 3 to 9, Part 2, Schedule 1 of the Rules. A Type A procedure also includes a certified Type B procedure or a certified overnight Type C procedure: definition of ‘Type A procedure’ in rule 3 of Part 1 of the Rules.

2. Minimum benefit

Clause 2 (1) provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 1 of Schedule 2 is the amount set out in the table in Schedule 2.

Schedule 3 – Same-day accommodation: hospitals in all States/Territories

Part 1 - General

1. Circumstances

Clause 1 provides that Schedule 3 applies, where a policy covers a type of hospital treatment, and the treatment:

- is provided to a patient at a hospital; and
- is provided to a patient who is not a nursing-home type patient; and
- is a Type B procedure; and
- does not include part of an overnight stay at a hospital.

Type B procedures are procedures specified in clauses 3 to 7 of Schedule 3. A Type B procedure also includes a certified Type C procedure: definition of 'Type B procedure' in Rule 3 of Part 1 of the Rules.

2. Minimum benefit

Clause 2 (1) provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 1 of Schedule 3 is the amount set out in Table 1 or 2 of clause 2, Schedule 3.

Clause 2 (2) provides for the meaning of references to 'Bands' in Tables 1 or 2 of clause 2, Schedule 3 (as applicable).

Part 2 – Type B procedures

3. Interpretation

Clause 3 provides that a Type B procedure is a procedure specified as a Band 1, 2, 3, or 4 as described in clauses 3 to 9, Part 2, Schedule 3.

Types of hospital treatment are classified into four specific bands based on the type of procedure and factors such as the type of anaesthetic used and theatre time.

4. Band 1

Clause 4 provides that for the purpose of the table in clause 2 of Schedule 3, ***Band 1 treatment*** has the meaning given by clause 4.

Clause 4 provides that 'Band 1 treatment' is hospital treatment that involves a professional service of the type identified by the MBS item number specified in clause 4, or other treatment requiring day admission to a hospital that is not Band 2, 3 or 4 treatment.

Band 1 treatment includes specified category 3 therapeutic procedures and specified category 5 – diagnostic imaging services.

5. Non-band specific Type B day procedures

Clause 5 (1) provides that hospital treatment that involves a professional service of the type identified by the MBS item number specified in clause 5 is a non-band specific Type B day procedure.

Clause 5 (2) provides that a non-band specific Type B day procedure is Band 2, 3 or 4 treatment depending on anaesthetic type and, where applicable, theatre times as specified in clause 6 of this Schedule.

Clause 5 (3) provides that if a non-band specific Type B day procedure does not involve anaesthetic or theatre times, the minimum benefit is the benefit for Band 1 treatment.

6. Other bands

Clause 6 provides a definition of ***Band 2 treatment, Band 3 treatment and Band 4 treatment***.

7. Certified Type C procedure

Clause 7 (1) provides that minimum benefits for day-only accommodation provided for in Schedule 3 are payable for patients receiving a Type C procedure only if certification under subclause 7(2) is provided.

Clause 7 (2) provides the requirements which must be satisfied in order for a Type C procedure to receive certification for hospital treatment at a hospital for a period that does not include part of an overnight stay.

Type C procedures are procedures specified in clause 8, Part 3 of Schedule 3.

Part 3 – Type C procedures

8. Interpretation

Clause 8 provides that a Type C procedure is a procedure specified in clause 8 by reference to MBS items.

These procedures normally do not require hospital treatment. Clause 8 specifies certain items in the general medical services table, the diagnostic imaging services table, and the pathology services table.

Schedule 4 – Nursing-home type patient accommodation: hospitals in all State/Territories

1. Circumstances

Clause 1 provides that Schedule 4 applies, where a policy covers a type of hospital treatment, and the treatment is provided to a nursing-home type patient at a hospital

A definition of ***nursing-home type patient*** appears in rule 3 of Part 1 of the Rules. Nursing-home type patient has the same meaning as in subsection 3(1) of the *Health Insurance Act 1973*.

On and from 1 April 2007 a nursing-home type patient, in relation to a hospital, means a patient in a hospital who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days.

2. Minimum benefit

Clause 2 provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 1 of Schedule 4 is the amount set out in Table 1 or 2 of Schedule 4 (as applicable).

Schedule 5 – Second-tier default benefits

The purpose of second-tier default benefits is to protect quality private facilities and to provide an incentive for private facilities to become accredited and meet other administrative criteria, hence increasing the level of quality hospital care available to consumers.

Schedule 5 sets the minimum benefits for most episodes of hospital treatment (excluding treatment provided to nursing-home type patients) provided at private hospitals specified in Schedule 5 payable by insurers with which the private hospital does not have a negotiated agreement.

The Schedule 5 minimum benefit will generally be higher than the basic minimum benefit set by Schedules 1, 2, 3 or 6 of the Rules. However, if in a particular case the level of benefit set by Schedule 5 should be less than the level of benefit set by Schedules 1, 2, 3 or 6, then the level of benefit set by Schedules 1, 2, 3 or 6 (as applicable) applies.

1. Interpretation

Clause 1 (1) provides the definitions of ***facility*** and ***negotiated agreement*** for the purpose of Schedule 5. A ***facility*** means a private hospital specified in clause 4 of Schedule 5.

Clause 1 (2) provides that in Schedule 5, the ACT is taken to be part of NSW and the Northern Territory is taken to be part of the State of South Australia.

Clause 1 (3) provides that private hospitals are comparable if they fall within the same category from the list contained in this clause.

Clause 1 (4) provides for a definition of the term ***licensed beds***.

2. Circumstances

Clause 2 provides that Schedule 3 applies, where a policy covers a type of hospital treatment, and the treatment:

- is provided to a patient who is not a nursing-home type patient; and
- the treatment is provided at a facility.

3. Minimum benefit

Clause 3(1) provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 1 of Schedule 5 is the amount worked out using the method set out in Schedule 5.

Clause 3 (2) provides that if the minimum benefit worked out in accordance with the method set out in Schedule 5 for an episode of hospital treatment is below the amount set out in Schedules 1, 2, 3, or 6 the minimum benefit is the amount set out in Schedules 1, 2, 3, or 6 for that episode of hospital treatment.

Clause 3 (3) provides that if a hospital ceases to be a facility, the minimum benefit continues to apply as if the hospital continued to be a facility at the time the treatment was provided, in relation to insured person's who were admitted patients at the facility, or booked for hospital treatment at the facility, before the hospital ceased to be a facility.

Clause 3(4) provides that the minimum benefit payable by a private health insurer for an episode of treatment is an amount no less than 85% of the average charge for the equivalent episode of hospital treatment under that insurer's negotiated agreements with all comparable private hospitals in the State in which the facility is located.

Clause 3(4) also provides the timeframes for the calculation of 85% of the average charge for an equivalent episode of hospital treatment.

Clause 3 (5) provides for the formula for calculating the ***average charge for the equivalent episode of hospital treatment*** by an insurer in each State.

Clause 3 (6) provides that in subclause 3(4), each ***episode of hospital treatment*** must be identified using the patient classification system and payment structure in force on 1 August of the first year with all comparable private hospitals in the State in which the facility is located.

Clause 3 (7) provides that in subclause 3(4), for the purpose of calculating the ***average charge for the equivalent episode of hospital treatment*** in a State with all comparable private hospitals in the State in which the facility is located certain matters are to be included, and certain matters are not to be included.

Clause 3 (8) provides the method for calculating the minimum benefit for insurers with less than 5 negotiated agreements in force on 1 August of the first year with a particular category of comparable private hospitals in a State. In such cases, all of that insurer's negotiated agreements with all categories of private hospital in that State are to be used to calculate the minimum benefit.

4. Facilities

Clause 4 provides that the hospitals specified in the table to Schedule 5 are facilities for the purpose of Schedule 5.

Schedule 6 – Outreach services

1. Application

Clause 1 provides that this Schedule, which sets a minimum benefit for outreach services, ceases to have effect at midnight on 30 June 2008.

Schedule 6 sets the minimum benefit payable for outreach services approved under section 5D of the *National Health Act 1953* prior to 1 April 2007 (also known as hospital in the home).

Section 16 of the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* provides for outreach services determined under section 5D to be treated as hospital treatment under the *Private Health Insurance Act 2007* from 1 April 2007 until 1 July 2008. The minimum benefit amounts set out in Schedule 6 will be payable for approved outreach services until 1 July 2008. From that date, hospitals providing treatment at a location other than at the hospital will need to make arrangements with health insurers about the amount of benefit payable for that treatment.

2. Circumstances

Clause 2 provides that Schedule 6 applies, where a policy covers a type of hospital treatment, and the treatment is an outreach service.

3. Minimum benefit

Clause 3 provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 2 of Schedule 6 is the amount set out in Table 1 or 2 in Schedule 6 (as applicable).