EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health and Ageing

Private Health Insurance Act 2007

Private Health Insurance (Complying Product) Rules 2007

Section 333-20 of the *Private Health Insurance Act 2007* (the Act) provides that the Minister may make *Private Health Insurance (Complying Product) Rules* (the Rules) providing for matters required or permitted by Chapter 3 the Act, or necessary or convenient in order to carry out or give effect to Chapter 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), and the *Private Health Insurance Incentives Act 1998*, into the new *Private Health Insurance Act 2007* (PHI) (and Private Health Insurance Rules made under the PHI).

The Act requires that health insurance products must comply with a range of requirements including that products: be community-rated, that is, made available in a way that does not discriminate between people; be in the form of a complying health insurance product; and that private health insurers who make the products available must meet certain obligations to people insured or seeking to be insured under the products.

The Rules continue to set the maximum percentage of discount at 12 % per year. The Rules also ensure that former gold card holders are not required to serve waiting periods when they first join a health fund. Transitional arrangements have also been made for specified benefits including benefits made in connection with the birth of a baby, funeral benefits and disability benefits.

The Act imposes a requirement on health insurers to provide standard information statements for all complying health insurance products they sell. The Rules set out the form and content of a standard information statement and ensure that the information provided by health insurers is in a standardised form to allow consumers to compare health insurance products. The effect of these Rules is that consumers will be better informed as they will be able to compare products from different health insurers more easily.

Schedules 1 to 4 relate to standard information statements.

Private health insurers were extensively consulted and provided with opportunities to comment upon the new Private Health Insurance legislative package. Draft Rules were published on the Departmental website for comment, and information sessions were held to provide industry stakeholders with the opportunity to be consulted on the making of the Rules.

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 (COMPLYING PRODUCT) RULES 2007*

PART 1 - Preliminary

1. Name of Rules

Rule 1 provides that the title of the Rules is the *Private Health Insurance (Complying Product) 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 provides that terms used in the Rules have the same meaning as in the Act. Rule 3 also defines specific terms used in the Rules.

PART 2 - General

4. Insured Groups

Rule 4 provides for the purposes of paragraph 63-5 (2A) (b) of the Act, the insured groups which are referred to by the number of people in each group.

5. Maximum percentage of discount

Rule 5 (1) provides that the maximum percentage discount allowed for the categories of people listed under section 66-5 (1) (c)(ii) of the Act is 12% per annum.

Rule 5 (2) provides that the discount for a policy is the difference between the full premium and the net premium.

Rule 5 (3) provides that the definition of a full premium is the premium that would be received by the private health insurer for a policy in the same product subgroup covering the same combination of people without any reduction due to the circumstances set out in paragraphs 66-5(3)(a) to (e) of the Act. For example, people who pay a premium at least 3 months in advance, or who pay a premium by payroll deduction or automatic transfer.

Rule 5 (4) provides that the net premium is the full premium less any cost listed in the Rules such as incentive payment, rebate and any other deductions.

6. Benefits authorised to be provided under a policy

Subrule 6 (1) provides that ***specified benefit*** means a benefit specified in subrule 6 (3).

Subrule 6 (2) provides that if a person was entitled to a specified benefit as listed in subrule 6 (3), under an applicable benefits arrangement or a table of ancillary health benefits as in force at the commencement of the Act, the provision of the same specified benefit under the person's policy continues to be authorized for the purposes of paragraph 69-1(1)(b) of the Act as long as the policy continues to cover the same specified treatments and to provide the same benefits.

Subrule 6 (3) provides that specified benefits for Rule 6 are benefits paid in connection with the birth of a baby, funeral benefits, and disability benefits.

Subrule 6 (4) provide that ***ancillary health benefit*** has the same meaning as under section 67 of the *National Health Act 1953* as in force immediately before the commencement of the Act.

7. Complying products – coverage requirements

Section 69-1 of the Act provides that the only treatments a complying health insurance policy can cover are:

- specified treatments that are hospital treatment; or
- specified treatments that are hospital treatment and specified treatments that are general treatment; or
- specified treatments that are general treatment but none that are hospital-substitute treatment.

An insurance policy meets the coverage requirements if the policy provides a benefit for anything else and the provision of that benefit is authorized by the Private Health Insurance (Complying Product) Rules.

Subsection 69-1(2) of the Act provides that the policy must also cover any treatment that a policy of its kind is required by the Rules to cover.

Rule 7 (1), made for the purpose of subsection 69-1(2) of the Act, provides in Item 1 that a policy that includes cover for hospital-substitute treatment, must also cover hospital treatment for the *same types of treatment* covered by the policy for hospital-substitute treatment.

Subrule 7 (1) also provides that a policy that covers hospital treatment either partly or wholly must cover Item 2 the provision of the prosthesis where it includes a prosthesis listed in the Private Health Insurance (Prostheses) Rules and either:

(a) a medicare benefit is payable for the professional service associated with the provision of the prosthesis; or
(b) the provision of the prosthesis is associated with podiatric treatment by an accredited podiatrist.

Under Item 3 a policy that wholly or partly covers hospital-substitute treatment where the treatment includes a prosthesis listed in the Private Health Insurance (Prostheses) Rules and a medicare benefit is payable in respect of the professional services associated with the prosthesis, must also cover provision of the prosthesis.

Rule 7 (2) provides, for the avoidance of doubt, that a policy that includes cover for hospital-substitute treatment, though required by Rule 5(1) to also provide cover for the same types of hospital treatment, may *also* cover other types of hospital or general treatment.

8. Waiting periods – former gold card holders

Rules 8 provides that no waiting period or benefit limitation period applies to former gold card holders, or persons entitled to treatment under a Department of Veterans' Affairs gold card, when obtaining private health insurance.

Rule 8 (1) provides that the waiting period requirements in section 75-1 of the Act are, as permitted by subsection 72-1(2) of the Act, modified by Rule 7.

Rule 8 (2) provides that if the person applies for insurance no longer than 2 months after the person ceases to hold, or have entitlements under the gold card, waiting periods or benefit limitation periods will not apply for any hospital treatment or general treatment covered by the policy.

Rule 8 (3) provides that ***gold card*** has the same meaning as in section 34-15 of the Act. Section 34-15 of the Act provides that a ***gold card*** is a card that evidences a person's entitlement to be provided with treatment in accordance with the Treatment Principles prepared under section 90 of the *Veterans' Entitlements Act 1986,* or, in accordance with a determination made under section 286 of the *Military Rehabilitation and Compensation Act 2004.*

Benefit limitation period is defined as the period starting at the time the person becomes insured under the policy and ending at the time specified in the policy, during which the amount of benefit in relation to the period is less than the amount for which the person would be eligible during any other period.

9. Transfer certificates

Rule 9 sets out the time periods within which an old insurer must provide a transfer certificate to a former insured person, a new insurer must request a transfer certificate from an old insurer, and an old insurer must provide a transfer certificate to a new insurer.

10. Performance indicators

Rule 10 provides for the performance indicators to be used by the Minister in monitoring private health insurers' compliance with the principle of community rating. The performance indicators listed in the Rules include, for example, the number and kind of complaints made to the Private Health Insurance Ombudsman about private health insurers, and changes in the number of episodes of hospital treatment and hospital-substitute treatment (and the average number of episodes of each) for particular age groups.

PART 3 - Standard Information Statements

11. Definitions

Rule 11 defines specific terms used for the purpose of this Part.

12. Information and form

Rule 12 (1) provides that Part 4 of the Rules, and Schedules 1, 2, 3, and 4 set out the permitted form and content of a statement about a complying health insurance product.

Rule 12 (2) requires that no additions, deletions, rearrangement or modification can be made to the form or content of the statements in Schedules 1, 2 and 3, except as specified in the relevant Schedules, or to omit, when inapplicable, the grey text, or to omit text for which the grey text is the appropriate alternative.

Rule 12 (3) requires that a statement must not exceed one A4 page, except in the case of a policy covering both hospital and general treatment where the statement must not exceed two A4 pages.

13. Policies covering hospital treatment only

Rule 13 provides that for policies covering hospital treatment only, the statement must be in the form set out in Schedule 1 and must contain the permitted content specified in Parts 1 and 2 of Schedule 4 as is relevant to the particular product.

14. Policies covering general treatment only

Rule 14 provides that for policies covering general treatment only, the statement must be in the form set out in Schedule 2 and must contain the permitted content specified in Parts 1 and 3 of Schedule 4 as is relevant to the particular product.

15. Policies covering hospital and general treatment

Rule 15 provides that for policies covering both hospital and general treatment, the statement must be in the form of the statement set out in Schedule 3, must contain the permitted content specified in Parts 1, 2 and 3 of Schedule 4 as is relevant to the particular product, and must not exceed two A4 pages.

Schedule 1 – Standard information statements: hospital treatment

This schedule provides for the form of statements for hospital treatment as set out in **Part 3 Standard information statements** of these Rules.

Schedule 2 – Standard information statements: general treatment

This schedule provides for the form of statements for general treatment as set out in **Part 3 Standard information statements** of these Rules.

Schedule 3 – Standard information statements: combined products

This schedule provides for the form of statements for combined products as set out in **Part 3 Standard information statements** of these Rules.

Schedule 4 – Standard information statements: permitted content

This schedule provides for the permitted content for all statements as set out in **Part 3 Standard information statements** of these Rules.