EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health and Ageing

Private Health Insurance Act 2007

Private Health Insurance (Health Insurance Business) Rules 2007

Section 333-20 of the *Private Health Insurance Act 2007* (the Act) provides that the Minister may make *Private Health Insurance (Health Insurance Business) Rules* (the Rules) providing for matters required or permitted by Part 4-2 of the Act, or necessary or convenient in order to carry out or give effect to Part 4-2 of the Act.

Combined with the *Private Health Insurance (Risk Equalisation Policy) Rules 2007* (Risk Equalisation Policy Rules) and the Act, these Rules provide for private health insurers to expand hospital products to cover a broader range of services that substitute for or prevent hospitalisation, and categorise privately insured services as being hospital or general treatment.

These Rules provide for inclusions and exclusions to the definitions of 'hospital treatment' and 'general treatment' in the Act.

The Rules specify the statistical information that will be required to be provided by hospitals to insurers and hospitals to the Department. They also include a number of other matters that the Minister is to have regard to when declaring or revoking a declaration that a facility is a hospital.

The effect of the Rules (together with the Act) is that private health insurers are able to make arrangements with healthcare providers for the payment of benefits for clinically appropriate alternatives to in-hospital treatment and for disease management and prevention programs. It is not mandatory for insurers to offer products that cover these types of services.

The inclusion of these types of services in the risk equalisation arrangements will enable the costs of these services to be shared by health insurers. Risk equalisation arrangements are provided for in the Risk Equalisation Policy Rules.

The Rules set out the treatments that are excluded from 'health insurance business' and therefore from attracting the Private Health Insurance Rebates. The Rules reflect the previous regulation relating to exclusions from 'health insurance business' contained in old regulations 47 and 48 of the *National Health Regulations 1954*, made for the purpose of section 67 of the *National Health Act 1953*, with the following differences:

- Rule 17 excludes overseas visitors health cover (OVHC) from health insurance business, whether or not the business is conducted by a private health insurer; and
- Rule 18 creates a new category of specified temporary visa health cover, which, like overseas student health cover (OSHC), is subject to community rating, and may be offered by private health insurers in accordance with a written agreement between the Commonwealth and the insurer.

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 Attachment A.

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 A

DETAILS OF THE *PRIVATE HEALTH INSURANCE (HEALTH INSURANCE BUSINESS) RULES 2007*

Part 1 Preliminary

1. Name of Rules

Rule 1 provides that the title of the Rules is the *Private Health Insurance (Health Insurance Business) 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 notes that the terms used in these Rules have the same meaning as in the *Private Health Insurance Act 2007*.

Part 2 Hospitals

4. Information to be provided by hospital to insurers

Paragraph 121-5 (7) (e) of the Act provides that in deciding whether to declare that a facility is a hospital, or to revoke such a declaration, the Minister must have regard to whether undertakings have been made, or have been complied with, relating to providing to private health insurers information, of the kind specified in these Rules, relating to treatment of insured persons with health benefits funds.

Subrule 4 (1) provides that information of the kind described in the Hospital to Fund Specifications document relating to treatment of insured persons is specified for the purpose of in paragraph 121-5 (7) (e) of the Act.

Subrule 4 (2) defines ***Hospital to Fund Specifications document*** to mean the document that sets out the data specifications for data provided by hospitals to private health insurers that was approved by the Assistant Secretary of Private Health Insurance Branch, Department of Health and Ageing on 22 April 2007. The document can be found on the Department of Health and Ageing website at: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-casemix-data-collections-about-HCP.

Subrule 4 (3) provides for certain modifications to the Hospital to Fund Specifications document referred to in subrule 4 (2).

5. Matters to which the Minister is to have regard in declaring that a facility is a Hospital

Paragraph 121-5 (7) (f) of the Act provides that in deciding whether to declare that a facility is a hospital, or to revoke such a declaration, the Minister must have regard to any other matters (being matters in addition to those listed in subsection 121-5 (7)) specified in the Rules.

Rule 5 specifies certain matters to which the Minister must have regard when deciding whether to declare that a facility is a hospital. These include, for example, whether or not declaration of the premises as a private facility would materially affect reasonable access by public patients to a reasonable range of services, and, in the case of a private facility which was previously part of a public hospital, whether or not undertakings have been made relating to providing to the Department with required patient data.

6. Matters to which the Minister is to have regard in revoking a declaration that a facility is a hospital

Rule 6 specifies certain matters to which the Minister must have regard in deciding whether to revoke a declaration that a facility is a hospital. These include, for example, if there is an undertaking by the facility's operator to provide to the Department the data specified in the Hospital to Fund Specifications in a patient de-identified state, whether the facility has provided that data within 6 weeks after the insured person to whom the information relates has been discharged from the hospital.

7. Conditions on declarations of hospitals

Subrule 7 (1) provides that for subsection 121-7 (2) of the Act, a declaration under paragraph 121-5 (6)(a) of the Act is subject to the conditions specified for this Rule.

Subrule 7 (2) provides that a private hospital is required to provide to the Department de-identified patient data specified in the Hospital to Commonwealth Specifications document, and this must be provided within 6 weeks after the insured person, to whom the information relates, has been discharged from the hospital. In the situation where the hospital provides triage and early treatment to a person in an emergency, the hospital must provide reasonable access to an appropriate range of services for treatment, or have arrangements for transfer to another facility for appropriate treatment.

Subrule 7 (3) provides that the ***Hospital to Commonwealth Specifications document*** is the document approved by the Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing on 22 March 2007. The document can be found on the Department of Health and Ageing website at:
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-casemix-data-collections-about-HCP.
Modifications to the document are specified in subrule 4(3).

Part 3 Hospital and general treatment

8. Hospital treatment – excluded treatment

Rule 8 excludes four classes of treatments from the definition of hospital treatment and therefore precludes the payment of benefits for those treatments as hospital treatment by private health insurers. These are: services normally not requiring hospital treatment; treatment provided in an emergency department of a hospital; and treatment provided to a

newly born child whose mother also occupies a bed in the hospital, except in certain circumstances; and treatment which is part of a chronic disease management program which is intended to delay the onset of chronic disease

Rule 8, paragraph (a) excludes specific professional medical services that normally do not require treatment in a hospital. These services are identified by Medicare item numbers set out in clause 8 of Schedule 3 of the *Private Health Insurance (Benefit Requirements) Rules 2007* (the Benefit Requirements Rules). They are professional attendances and particular diagnostic imaging and pathology services (referred to as ***Type C Procedures*** in the Benefit Requirements Rules).

However, private health insurers can pay benefits for hospital treatment if the medical practitioner providing the professional service has provided a certificate in accordance with clause 7 of Schedule 3 of the Benefit Requirements Rules stating that it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital for a period that does not include part of an overnight stay. A Type C procedure may, in addition, be certified for hospital treatment which includes part of an overnight stay, in accordance with clause 11 of Schedule 1 of the Benefit Requirements Rules.

Rule 8, paragraph (b) excludes from hospital treatment, treatment provided to a person at an emergency department of a hospital.

Rule 8, paragraph (c) provides that excluded treatment means treatment provided to a person who is not a patient within the meaning of the word in paragraph (b) in subsection 3(1) of the *Health Insurance Act 1973*.

The Note in this Rule provides that newly-born children are normally not admitted to hospital when the mother is admitted. Newly-born children may be admitted, and private health insurance benefits may be paid for hospital treatment, if the child is not the first child of a multiple birth, or if the newly-born child occupies an approved bed in an intensive care facility in a hospital.

Rule 8, paragraph (d) excludes treatment that is part of a chronic disease management program that is intended to delay the onset of disease for a person with identified multiple risk factors for chronic disease.

9. General treatment – included treatment

Rule 9 provides for the inclusion of ambulance services associated with the provision of treatment to an insured person within the definition of general treatment in the Act.

10. General treatment – services for which medicare benefit is payable

Paragraph 121-10 (3) of the *Private Health Insurance Act 2007* precludes the payment of private health insurance benefits under general treatment for professional services for which a medicare benefit is payable, unless these Rules provide otherwise.

Rule 10 permits the payment of private health insurance benefits, as part of ***hospital-substitute treatment***, for specified professional medical therapeutic services in groups T1 to T11 of the general medical services table (the red section of the Medicare

Benefits Schedule Book) and oral and maxillofacial services in groups O1 to O11 (the grey section of the Medicare Benefits Schedule Book).

Specifically, the services are those for which a medicare rebate of 85% of the schedule fee is payable if the service is performed at a location other than at a hospital.

Benefits are also payable for associated pathology and diagnostic imaging services where they are integral to the provision of the professional medical therapeutic or oral and maxillofacial services e.g. fluoroscopy for transluminal stent insertion or histological examination with removal of basal cell carcinoma.

If a person chooses to receive a private health insurance benefit for ***hospital-substitute treatment***, then medicare benefit of 75% of the schedule fee is payable, and the Medicare safety nets do not apply. Item 3 in the Table in Section 72-1 of the *Private Health Insurance Act 2007* provides for the payment of a private health insurance benefit for ***hospital-substitute treatment*** for the professional medical service to be at least 25% of the schedule fee (or less if the charge for the treatment is less than the schedule fee).

11. General treatment – excluded treatment

Subrule 11 (1) excludes from the definition of general treatment, treatment (in the form of either goods or services), which is primarily for the purpose of sport, recreation or entertainment, except when such goods and services form part of a ***chronic disease management program*** or other health management program approved by the insurer. This rule reflects the old condition of registration in *Schedule A Conditions of registration* pursuant to paragraph 73B (1) of the *National Health Act 1953*.

In subrule 11 (2) a ***health management program*** is defined as a program to ameliorate a person's specific health condition or conditions.

12. Chronic disease management programs

Subrule 12 (1) defines a ***chronic disease management program*** as a program that is intended to reduce complications in a person with a diagnosed chronic disease, or to prevent or delay the onset of chronic disease in a person with identified multiple risk factors for chronic disease. A ***chronic disease management program*** also requires the development of a written plan, and a co-ordinator.

Benefits paid for the planning, coordination and allied health service components of a chronic disease management program are ***eligible benefits*** for the purposes of the Risk Equalisation Policy Rules.

The planning component of a ***chronic disease management program*** (set out in paragraph 12 (1)(b) of the definition of ***chronic disease management program***) involves the preparation of a written plan that specifies: the allied health service or services and any other goods and services required to be provided to the patient, the frequency and duration of the provision of those goods and services, and the date for review of the plan. The plan must be provided to the patient for consent, and consent given, before any services under the program are provided.

The coordination component of a ***chronic disease management program*** (set out in

paragraph 12(1)(c) of the definition of ***chronic disease management program***) involves a person accepting responsibility for ensuring the services are provided according to the plan, and monitoring the patient's compliance with the agreed goals and activities of the program.

Subrule 12 (2) provides a definition of ***allied health service*** for the purpose of the definition of ***chronic disease management program***. The definition lists the relevant allied health professionals for allied health services. These professionals are the same allied health professionals who are eligible to claim medicare benefits for services of the type provided under the chronic disease management programs.

Subrule 12 (2) also defines '***risk factors for chronic disease'*** and '***chronic disease'*** for the purpose of the definition of ***chronic disease management program***. The definition used for 'risk factors for chronic disease' and 'chronic disease' is the same as the definition used for 'specific risk factors' and 'chronic disease' in Rule 12AA of the *Health Insurance (General Medical Services Table) Regulations 2006* for the purposes of medicare item 717 for health checks for 45-49 year olds.

Part 4 Health insurance business

13. Business that is not accident and sickness insurance

Section 121-20 of the Act excludes accident and sickness insurance from the definition of 'health insurance business'. That is, it provides that 'health insurance business' does not include the business of undertaking liability, by way of insurance, to pay a lump sum, or to make periodic payments, on the happening of a personal accident, disease or sickness.

However, the exclusion contained in section 121-20 does not apply to business where liability is undertaken with respect to loss arising out of a liability to pay fees or charges in relation to the provision in Australia of hospital treatment or general treatment, or, business of a kind specified in the Rules.

Subrule 13 (1) specifies certain kinds of business for the purpose of section 121-20 of the Act. The rule reflects old regulation 47 of the *Health Insurance Regulations 1954*, made for the purpose of section 67 of the *National Health Act 1953*.

Subrule 13 (2) provides for the definition of ***relevant health services***.

14. Health insurance business: exclusions in respect of certain goods

Section 121-30 of the Act provides that health insurance business does not include business of a kind that the Rules state not to be health insurance business. Rule 14 is made for the purpose of section 121-30 of the Act. It reflects old regulation 48 (2) of the *National Health Regulations 1954*, made under section 67 of the *National Health Act 1953*, except that it applies to both non-private health insurers and private health insurers.

Subrule 14 (1) defines ***relevant service*** for the purpose of rule 14.

Subrule 14(2) provides that the business of undertaking liability, by way of insurance, or an arrangement to make payments under an employee health benefits scheme, with respect to the provision of a ***relevant service*** (ie, supply, alteration, maintenance or repair of certain goods such as hearing aids and spectacles), by way of indemnity for damage to, or loss of such

goods, is not health insurance business, unless the insurance policy primarily covers hospital treatment, general treatment, or both.

15. Insurance that is not health insurance business

Section 121-30 of the Act provides that health insurance business does not include business of a kind that the Rules state not to be health insurance business. Rule 15 is made for the purpose of section 121-30 of the Act. It reflects old regulation 48(1) of the *National Health Regulations 1954*, made under section 67 of the *National Health Act 1953*, except that it applies to both non-private health insurers and private health insurers.

Subrule 15 (1) provides that the business of undertaking liability, by way of insurance, or an arrangement to make payments under an employee health benefits scheme, is not health insurance business if the insurance covers a matter referred to in subsection 121-1(2) of the Act, and a person referred to in any of subrules 15(3) to (8) in the circumstances stated in that subrule.

Subrule 15 (2) provides that this Rule does not limit the operation of a person's complying health insurance policy that covers the relevant treatment.

Subrule 15 (3) applies to a resident temporarily employed outside Australia in certain circumstances.

Subrule 15 (4) applies to a person on board a cruise ship in certain circumstances.

Subrule 15 (5) applies to volunteers, and persons engaged in sporting and youth activities in certain circumstances.

Subrule 15 (6) applies to persons engaged in student activities in certain circumstances.

Subrule 15 (7) applies to secondary school students in certain circumstances.

Subrule 15 (8) applies to people undertaking Commonwealth-funded activities in certain circumstances.

16. Health insurance business: death or disability benefits

Section 121-30 of the Act provides that health insurance business does not include business of a kind that the Rules state not to be health insurance business. Rule 16 is made for the purpose of section 121-30 of the Act. It reflects old regulation 48 (2A) of the *National Health Regulations 1954*, made under section 67 of the *National Health Act 1953*.

Subrule 16 (1) provides that the business of undertaking liability, by way of insurance, is not health insurance business where the liability is for matters such as: death benefits, benefits payable if the insured is more likely than not to die within 2 years after making a claim for illness or injury, or benefits payable as income replacement.

Subrule 16 (2) provides that Rule 16 does not apply if the provision of a benefit is authorised under rules made for the purpose of paragraph 69-1(1)(b) of the Act.

17. Insurance that is not health insurance business – certain overseas visitors

Section 121-30 of the Act provides that health insurance business does not include business of a kind that the Rules state not to be health insurance business. Rule 17 is made for the purpose of section 121-30 of the Act. It reflects old regulation 48(1)(a) of the *National Health Regulations 1954*, made under section 67 of the *National Health Act 1953*, except that it applies to both non-private health insurers and private health insurers.

Subrule 17 (1) provides that the business of undertaking liability, by way of insurance, or an arrangement to make payments under an employee health benefits scheme, is not health insurance business if the insurance covers a matter referred to in subsection 121-1(2) of the Act, and covers a person who is a temporary visitor to Australia, as defined in rule 17.Subrule 17 excludes overseas visitors health cover from health insurance business.

Subrule 17 (1) provides that this exclusion from health insurance business does not apply in respect of an overseas student or a specified temporary visa holder who has insurance provided in the circumstances referred to in rule 18. Overseas student and specified temporary visa holder health insurance contracts are dealt with in Rule 18.

Subrule 17 (2) provides that despite subrule 17 (1), the business referred to in subrule 17 (1) during the period from the commencement of these Rules until 1 July 2008, is health insurance business if it is conducted by a private health insurer.

18. Overseas students and specified temporary visa holders

Rule 18 is made for the purpose of section 121-30 of the Act. It reflects old regulation 48 (2B) and (3) of the *National Health Regulations 1954*, made under section 67 of the *National Health Act 1953*, which dealt with Overseas Student Health Cover (OSHC), except that an additional category called ***specified temporary visa holder health insurance contract*** is introduced.

Section 131-10 of the Act permits a private health insurer to include overseas student health insurance contracts and specified temporary visa holder health insurance contracts as health-related business, in addition to health insurance business. A 'health-related business' is defined in section 131-15 to include 'a business of undertaking liability, by way of insurance, to indemnify people who are ineligible for Medicare for costs associated with providing treatment, goods or services that are provided to those people in Australia, and are provided to manage or prevent diseases, injuries or conditions.'

If a private health insurer has a health benefits fund which includes health-related business, section 137-30 of the Act requires the insurer to comply with any requirements specified in the *Private Health Insurance (Health Benefits Fund Policy) Rules 2007* (Health Benefits Fund Policy Rules) relating to how health-related businesses are to be conducted. Rule 5 of the Health Benefits Fund Policy Rules requires private health insurers to conduct overseas student health cover and specified temporary visa health cover in accordance with the principles of community rating.

Subrule 18 (1) provides that the business of undertaking liability, by way of insurance, is not health insurance business if the insurance covers a matter referred to in subsection 121-1(2) of the Act, the liability is undertaken by a private health insurer under an overseas student health insurance contract or a specified temporary visa holder health insurance contract, and

the business is included in a health benefits fund of the insurer.

Subrule 18 (2) provides definitions for ***overseas student***, ***overseas student health insurance contract***, ***specified temporary visa holder health insurance contract***, ***specified temporary visa holder***, and ***student visa***.