EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health and Ageing

Private Health Insurance Act 2007

Private Health Insurance (Risk Equalisation Policy) Rules 2007

Section 333-20 of the *Private Health Insurance Act 2007* (the Act) provides that the Minster may make *Private Health Insurance (Risk Equalisation Policy) Rules* (the Rules) providing for matters required or permitted by Part 6-7 of the Act, or necessary or convenient in order to give effect to Part 6-7 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 was moved from the *National Health Act 1953* (NHA) (and regulations under the NHA), into the new Act (and Private Health Insurance Rules made under the Act).

Section 318-1 of the Act continues the existence of the Health Benefits Reinsurance Trust Fund established under section 73BC of the NHA. It is re-named the Private Health Insurance Risk Equalisation Trust Fund (the Risk Equalisation Trust Fund or the Fund).

Section 318-10 of the Act provides that the Risk Equalisation Policy Rules may set out requirements relating to how the Risk Equalisation Trust Fund is to operate. Without limiting the matters which may be dealt with in the Rules, the Rules must specify the method for working out the amount to be paid out of the Fund to a private health insurer, and the method for working out the amount to be paid into the Fund by private health insurers as risk equalisation levy. The Rules also provide the method for calculating adjustment amounts where there has been an error in the amount paid into or out of the Fund.

The risk equalisation levy is imposed under the *Private Health Insurance (Risk Equalisation Levy) Act 2003* (the Levy Act). The rate of the levy is set by a determination made by the Private Health Insurance Administration Council (the Council) under the Levy Act. The Levy Act provides that in determining the rate of levy the Council and the Minister must comply with the Risk Equalisation Policy Rules made under the Act.

The Rules and the Levy Act introduce the new High Cost Claimants Pool and extend the Age Based Pool.

Risk equalisation applies to 'eligible benefits' paid by a private health insurer. The Rules specify that 'eligible benefits' are benefits paid for:

- hospital treatment (other than the planning and coordination, and the allied health service, components of hospital treatment as specified in the Private Health Insurance(Health Insurance Business) Rules;
- hospital-substitute treatment; and
- general treatment in the form of the planning and coordination, and the allied health service, components of a chronic disease management program.

The purpose of including hospital-substitute treatment, and components of general treatment provided as part of a chronic disease management program, in risk equalisation is to

encourage the provision of the same or similar levels of treatment, and equal or better clinical outcomes for patients, as hospital admission.

The percentage of eligible benefits paid into the Age Based Pool (ABP) is based on Age Cohorts.

A separate risk equalisation pool will be maintained for each State as in the current arrangements. In the Rules the Northern Territory is taken to be a State, and the Australian Capital Territory is taken to be part of New South Wales.

Single parents are counted as 1 Single Equivalent Unit (SEU).

The underlying mechanisms of the new Risk Equalisation arrangements are:

Age Based Pool

- compulsory for all health benefits funds;
- the ABP operates first;
- pooling is based on benefits accumulated by claimant (patient) on a set percentage of benefits paid on the claimants age;
- the basis of respreading is the Single Equivalent Unit (SEU) calculated from hospital policies.

High Cost Claimants Pool

- compulsory for all health benefits funds;
- the HCCP operates after the ABP;
- pooling is based on benefits accumulated by claimant (patient);
- the threshold is $50,000;
- threshold revaluation will be examined but will not necessarily be taken up on an annual basis;
- the percentage to be pooled will be 82% (this is equal to the highest age pooling percentage);
- where net benefits after age pooling exceed the threshold, 82% of net benefits in excess of the threshold are to be pooled. A limit is imposed on total pooling under the ABP and the HCCP of 82% of gross benefits;
- the basis of respreading will be SEU calculated from hospital policies;
- quarters are linked by maintaining a running total by claimant over a rolling four quarter (12 month) basis. When assessing the HCCP in each quarter the current cumulative residual after the ABP is compared with the threshold level that applies at the time; and
- the geographic basis is by State with the same threshold applying to all States.

The new arrangements will commence at the same time as the Act commences; or, if the Rules are registered on or after the day on which the Act commences, on the date the Rules are registered, and will apply to the June 2007 quarter. There will be no transition period. The present methods concerning adjustment for unpaid contributions, new information concerning claimants and payment arrangements into and out of the Fund will remain unchanged.

If a policy holder with a private health insurer transfers to a new private health insurer the sum of benefits paid in respect of that claimant restarts from zero.

In the event of any merger between health benefits funds (whether or not with another insurer) the accumulated benefits paid in respect of each claimant is taken into the combined entity.

The Department engaged Ernst and Young to examine the proposed alterative risk equalisation models suggested by the Australian Health Insurance Association and the Health Industry Restricted Membership Association Australia and make recommendations on their operational arrangements. At the start of consultancy, the Department wrote to the chief executives and public officers of all private health insurers setting out the terms of reference for the consultancy and inviting them to make submissions concerning the proposed risk equalisation operational arrangements. During the consultancy, Ernst and Young met with the various private health insurers to discuss its draft recommendations before submission to the Department.

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.

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 (RISK EQUALISATION POLICY) RULES 2007*

Part 1 Preliminary

1. Name of Rules

Rule 1 provides that the title of the Rules is the *Private Health Insurance (Risk Equalisation Policy) 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. There will be no transition period.

3. Interpretation

Subrule 3 (1) provides the meaning of key words and phrases in the Rules.

Subrule 3 (2) provides that if a quarter falls within the term ***preceding three quarters***, a quarter that occurred before 1 April 2007 is not counted for the purpose of the calculations to which that term relates.

4. Single equivalent unit

Subrule 4 (1) provides that if a hospital policy falls into one of the categories of hospital policy specified in subrule 4 (2) the single equivalent unit for the hospital policy is the number shown next to the category in that subrule.

Subrule 4 (2) provides for the categories of hospital policies and the single equivalent unit for each category.

5. Eligible Benefits

Subrule 5 (1) provides that an ***eligible benefit*** means a benefit paid by an insurer:

(i) under a policy for general treatment in the form of the planning and coordination services and the allied health services components of a chronic disease management program, as described in the definition of chronic disease management program in the *Private Health Insurance (Health Insurance Business) Rules 2007* (the Business Rules); or

(ii) a policy for hospital-substitute treatment; or

(iii) a policy for hospital treatment other than treatment as part of a chronic disease management program, or a similar program regarding chronic disease except as mentioned in paragraph 5 (1)(d); or

(iv) a policy in accordance with paragraph 5 (1)(d) under which the planning and coordination and allied health services components of hospital treatment that is part of a chronic disease management program is included. Hospital treatment

which is part of a chronic disease management program is limited to treatment which is intended to delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease.

Subrule 5 (2) provides that the phrases ***chronic disease management program***, ***chronic disease*** and ***risk factors for chronic disease*** have the same meaning as in the Business Rules.

Subrule 5 (3) provides, for the avoidance of doubt, that benefits not covered by paragraph 5 (1) (a) include benefits paid for any other treatment as part of a chronic disease management program including, but not limited to, diagnosis of chronic disease or the identification of risk factors.

Part 2 Calculation of levy

6. Purpose of this Part

Rule 6 states that Part 2 of the Rules provides the method for working out the amount of levy to be paid, in respect of each health benefits fund, by each insurer as risk equalisation levy.

7. Matters to be taken into account

Subrule 7 (1) provides that matters mentioned in Rule 7 are to be taken into account on a State-by-State basis consistently with the organization of information presented for the quarter by the insurer in its quarterly return for a fund for a State.

Subrule 7 (2) provides for the matters that must be considered when calculating the amount of levy for each health benefit fund of an insurer, for a quarter. These matters include, for example, the age of each insured person in respect of whom an eligible benefit is paid in that quarter, the mean ***single equivalent units*** (SEUs) in the quarter, the amount of eligible benefit paid in the quarter and in the preceding three quarters, and any adjustment amount.

Subrule 7 (3) provides that to calculate the amount of levy in respect of a current quarter, the amount calculated using the formula in rule 7 (4) is first to be notionally allocated to the Age Based Pool (ABP). Then, if the amount of gross benefit not notionally allocated to the ABP in the current and preceding 3 quarters is greater than the designated threshold, a second amount is to be notionally allocated to the High Cost Claimants Pool (HCCP).

Subrule 7 (4) provides for the formula used when calculating the amount to be notionally allocated to the ABP in a quarter.

Subrule 7 (5) provides for the age cohorts which are set out in the table to this subrule. Set out below is an example of how to calculate the amount to be allocated to the ABP.

Example

Claimant is aged 57 and the claim size is $49,000

Component	Workings	Result
Age Based Pool	15% * $49,000	$7,350
High Cost Claimants Pool	Residual $42,500 less than threshold so no additional	-

	pooling	
Retained by Fund	$50,000 - $7,500	$41,650
Total		**$49,000**

Subrule 7 (6) provides that where an insured person receives treatment over a number of days such that the insured person falls within more than one age cohort, then the amount to be notionally allocated to the ABP must be allocated proportionately in accordance with the number of days during which the insured person was in each age cohort.

Subrule 7 (7) provides that an amount is to be notionally allocated to the HCCP for a current quarter in respect of an insured person providing the total amount allocated to the ABP and HCCP in accordance with subrule 7 (4) that is, the amount in eligible benefits less the ABP, less the HCCP threshold.

Subrule 7 (8) provides the formula to use when calculating the amount to be notionally allocated to the HCCP.

Example

Claimant is aged 57 and the claim size is $49,000

Component	Workings	Result
Age Based Pool	15% * $49,000	$7,350
High Cost Claimants Pool	Residual $42,500 less than threshold so no additional pooling	-
Retained by Fund	$50,000 - $7,500	$41,650
Total		**$49,000**

Claimant is Aged 63 and the claim size is $100,000

Component	Workings	Result
Aged Based Pool	42.5% * $100,000	$42,500
High Cost Claimants Pool	Residual $57,500 – threshold High Cost Claimants Pool 82% * (57,500 – 50,000)	$6,150
Retained by Fund	$100,000 - $48,650	$51,350
Total		**$100,000**

A limit is imposed on total pooling under the ABP and the HCCP of 82% of gross benefits.

Subrule 7 (9) provides the formula for calculating the total benefit paid into the HCCP under subrule 7 (8). This amount cannot exceed 82% of the total benefit paid.

Example

The claimant is aged 79 and the claim size is $350,000

Condition	Workings	Result
Age Based Pool	76% * 350,000	$266,000

High Cost Claimants Pool	Residual $84,000 > threshold, High Cost Claimants Pool Minium of 82%*(84,000 – 50,000) = $27,880 (82% - 76%) * 350,000 = $21,000	$21,000
Retained by Funds	$350,000 – $287,000	$63,000
Total		**$350,000**

Subrule 7 (10) provides that the designated threshold for an insured person is $50,000.

8. Payments by former insurer

Rule 8 provides that if an insurer has paid an amount of eligible benefit in respect to a policyholder and the policyholder moves to a new insurer then the amount of eligible benefit continues to be treated as a payment by the former insurer.

9. Payments where a health benefits fund is transferred

Subrule 9 (1) provides that where a health benefits fund of an insurer is transferred to another health benefits fund (whether or not also a new insurer) then the eligible benefit paid is to be treated as an eligible benefit paid by the receiving health benefits fund.

Subrule 9 (2) provides that if an insurer had paid an amount of levy into the Fund and if the health benefits fund is transferred to another health benefits fund (whether or not also a new insurer) then the amount of levy already paid into the Fund is to be treated as a levy payment by the receiving health benefits fund.

10. Effect of unpaid premiums

Rule 10 provides that if a policyholder has not paid their premiums for a period longer than 2 months after the end of the period for which premiums were last paid, and the insurer has given written notice to the person in whose name the policy is held that the policy is no longer in operation, a single equivalent unit is not to be taken into account for that terminated policy. If the insurer's rules allow for a longer period than 2 months, then the longer period applies.

11. Method of calculation

Subrule 11 (1) provides the method for calculating the amount of levy (if any) for each health benefits fund of an insurer for a particular quarter in respect of a State.

Subrule 11 (1)(a) provides that, first, for each fund, the total amount of the eligible benefits notionally allocated for the quarter in that State to the:

- ABP; and
- HCCP

is calculated and added together. For the total amount for the ABP, see subrule 7 (4) of the Rules, and for the total amount for the HCCP, see subrule 7 (8), or, if applicable, subrule 7 (9) of the Rules.

Subrule 11 (1)(b) provides that, second, the totals from (a) for each fund are summed to obtain a total for the State.

Subrule 11 (1)(c) provides that, third, the total of the average number of SEUs in that State for the quarter for all funds is calculated by determining under subrule 7 (2)(b) of the Rules the mean number of SEUs for each fund in the State, and adding these numbers together. This gives the paragraph (c) amount.

Subrule 11 (1)(d) provides that, fourth, the paragraph (b) amount is divided by the paragraph (c) amount. This calculates the average amount payable for each SEU.

Subrule 11 (1)(e) provides that, fifth, multiply the paragraph (d) amount by the paragraph (c)(i) amount. This is to obtain the total amount that would have been payable by the insurer in respect of the fund if the SEUs determined under subrule 7 (2)(b) for the fund had each been entitled to the amount calculated under paragraph (d).

Subrule 11 (1)(f) provides that, sixth, calculate the difference between the paragraph (e) amount and the paragraph (a) amount.

Example

Fund	**State Calculation ABP 11 (1) (a)(i)**	**State Calculation HCCP 11 (1) (a)(ii)**	**Total ABP+HCCP 11 (1)(a)**	**Average SEU 11 (1)(c)(11)**	**Average Amount per SEU (Calculated per state each quarter by PHIAC)**	**Amount payable at state average 11 (1)(e)**	**Differences 11 (1)(f)**	**Paid levy**	**Receive payment**
Fund 1	$750,000	$250,000	$1,000,000	10,830		1 17.99x10830 = $1,277,778	$277,777.78	$277,778.78	
Fund 2	$1,500,000	$500,000	$2,000,000	16,245		$117.99x16245 =$1,916,667	$83,333.33		$83,333.33
Fund 3	$2,000,000	$750,000	$2,750,000	21,660		$117.99x21660 = $2,55,556	$194,444.44		$194,444.44
Total	$4,250,000	$1,500,000	$5,750,000 See: 11(1)(c)(ii)	48,735 See: 11(1)(c)(ii)	$117.99 See: 11(1)(d)	$5,750,000.00		$277,778.78	$277,778.78

Subrule 11 (2) provides that where an adjustment amount has been determined under Part 4 to be taken into account in a particular quarter, the amount must be taken into account to increase or decrease, as the case requires, the amount that otherwise would be calculated under this rule.

Subrule 11 (3) provides that if an insurer fails to provide the Council with information required under the Risk Equalisation Administration Rules that is necessary to enable the Council to carry out the calculation referred to in this rule 11 for a quarter, the Council must carry out the calculation using the information last provided by the insurer for the relevant quarter and State.

12. Calculation of rate of levy

Subrule 12 (1) provides, subject to subrule 12 (2), that if the amount calculated under subrule 11 (1)(a) for an insurer is less than the amount calculated under subrule 11 (1)(e) after taking into account any adjustment amount, then the rate of levy imposed on an insurer on a risk equalisation day must be determined, for the quarter concerned, by the Council under the Levy Act, to be the amount equal to the difference.

Subrule 12 (2) provides that if an insurer has more than one health benefits fund in one or more States then the rate of levy for that insurer is determined by adding the amount of levy calculated for each of those funds, less any amount the insurer is to receive from the Fund in respect of a health benefits fund as determined in accordance with Part 3.

Part 3 Payments out of the Fund

13 Purpose of this Part

Rule 13 states that Part 3 provides the method for working out the amounts to be paid out of the Fund to insurers.

14. Matters to be taken into account

Subrule 14 (1) provides that the same matters are to be taken into account in calculating the amounts to be paid out of the Fund to an insurer for a particular quarter and in respect of a particular State, as are to be taken into account under Part 2 for amounts calculated as risk equalization levy.

Subrule 14 (2) provides that Rule 10 had the same application to this rule as it has to Rule 7.

15. Method of calculation

Rule 15 provides that the same method is to be applied in calculating the amount (if any) to be paid out of the Fund to an insurer in respect of a particular health benefits fund and particular State as is to be applied under Rule 11 in calculating the amount of levy (if any) for an insurer.

16. Amount of payment

Subrule 16 (1) provides, subject to subrule 16 (2), that if the amount calculated under subrule 11 (1)(a) for an insurer is more than the amount calculated under subrule 11 (1)(e), after taking into account any adjustment amount, the Council must determine that an amount equal to the difference is the appropriate amount to be paid out of the Fund to the insurer for the quarter concerned.

Subrule 16 (2) provides that if an insurer has more than one health benefits fund in one or more States then the amount to be paid out of the Fund for that insurer is to be determined by offsetting any amount of levy calculated in respect of each of those funds as determined in accordance with Part 2.

17. Manner and time of payment

Subrule 17 (1) provides, subject to subrule 17 (2), that the Council must make the payment calculated in accordance with Rule 16 to an insurer out of the Fund, and must do so without unnecessary delay.

Subrule 17 (2) provides that if an insurer has not paid the amount of levy (outstanding levy) imposed under the Levy Act within 14 days after the risk equalisation levy day, the Council must make an instalment payment to all insurers to which payment is due, by paying an amount proportional to the levies received for the quarter and the total amount due to each insurer.

Subrule 17 (3) provides that when any part of the outstanding levy is paid, the Council must make further instalment payments in the next quarter after the amount is received, proportionately to the amount due to the relevant insurers.

Subrule 17 (4) provides that the Council may make payment of any non-levy amounts in the Fund to insurers, but such payment must be made simultaneously to all insurers and must be determined proportionally for each insurer in accordance with the number of SEUs of that insurer in the quarter immediately before the payment is made.

Subrule 17 (5) states that ***non-levy*** in subrule 17 (4) means an amount referred to in subsection 318-5 (1) of the Act, other than levy.

Part 4 Calculating adjustment amounts

18. References to 'the Fund'

Rule 18 provides that in Part 4, references to 'the Fund' mean the Risk Equalisation Trust Fund or the Health Benefits Reinsurance Trust Fund established by section 73BC of the *National Health Act 1953*, as the case requires.

19. Calculation where error in amount paid as levy or amount paid or out of Fund

Subrule 19 (1) provides that if the Council receives new information concerning a matter mentioned in subrule 7 (2) of the Rules, or subsection 2.2 of the *Health Benefits Reinsurance (Trust Fund Principles) Determination 1998* (the Principles), that, if received earlier, would have affected the primary calculation under the relevant provision, the Council must make a new calculation of the amount that would have been the levy or would have been paid out of the Fund in respect of that quarter, taking into account the new information.

A primary calculation is defined in subrule 19 (1) to mean a calculation of the amount calculated as levy or paid out of the Fund to an insurer for a quarter under Rule 11 or 16, or under section 2.6 or 3.3 of the Principles.

Subrule 19 (2) provides that, unless subrule 19 (3) applies, a new calculation may only be made if the new information is received by the Council during or by the end of the first quarter following the financial year in which the particular quarter concerned occurs, or, within the period provided under subsection 169-5 (1) of the Act for a private health insurer to provide its annual report to the Council, being an annual report that relates to the particular quarter concerned.

Subrule 19 (3) provides that a new calculation may be made as a result of new information received by the Council later than is allowed under subrule 19 (2) if the Council is satisfied that the new information demonstrates that in preparing its annual report to the Council the insurer made a significant error, and, it is in the best interest of insurers generally and the good administration of the Fund that a further calculation be made.

These adjustments arise from significant error in reporting to the Council. 'Adjustment' does not refer to the normal day to day business of the insurer.

Subrule 19 (4) provides that any new calculation under subrule 19 (1) in respect of March 2007 and any other prior quarter is to be made in accordance with the *Principles* as in force immediately prior to 1 April 2007.

20. Application of new calculation to determine adjustment amount

Subrule 20 (1) provides that if the Council makes a new calculation under Rule 19 the Council must determine the adjustment amount in respect of the insurer for the quarter immediately following the calculation unless subrule 20 (3) applies.

Subrule 20 (2) provides that the Council must determine the adjustment amount by having regard to:

- the difference between the amount paid into the Fund by the insurer, or the amount paid out of the Fund to the insurer; and
- the amount that the new calculation demonstrates should have been paid as levy, or paid out of the Fund, in respect of that insurer.

Subrule 20 (3) provides that if the Council is satisfied that the financial stability of a particular insurer would be unreasonably affected if the whole of the adjustment amount for that insurer were taken into account in one quarter, or, the Fund would be unreasonably affected if the total of adjustment amounts for all insurers to be paid out of the Fund in one quarter were to be taken into account in that quarter, the Council may determine that an adjustment amount in respect of an insurer or insurers is to be applied over such number of quarters as the Council determines to be reasonable.

Subrule 20 (4) provides that ***unreasonably affected*** in rule 20 means, in the case of an insurer, in the Council's opinion the insurer's financial stability would be at risk if a new calculation is made under Part 4 and the adjustment amount was to be taken into account under Rule 13 in one quarter.

Subrule 20 (4) provides that ***unreasonably affected*** under this Part means, in the case of the Fund, if the total of the adjustment amounts to be taken into account in determining the amounts to be paid to insurers in a quarter under Part 3 would be greater than 1% of the amount, at the time the determination is made, of the State or Territory pool of the Fund from which the payment is to be made.