Private Health Insurance (Risk Equalisation Policy) Rules 2007

I, ANTHONY JOHN ABBOTT, Minister for Health and Ageing, make these Rules under item 15 of the table in section 333-20 of the *Private Health Insurance Act 2007*.

Dated 30 March 2007

TONY ABBOTT

Minister for Health and Ageing

Federal Register of Legislative Instruments F2007L00912

Contents

Part 1 Preliminary

1. Name of Rules

These Rules are the *Private Health Insurance (Risk Equalisation Policy) Rules 2007*.

2. Commencement

These Rules commence:

(a) if the Rules are registered before the Act commences—at the same time as the Act commences; or

(b) if the Rules are registered on or after the day on which the Act commences—on the date on which the Rules are registered,

whichever occurs first.

3. Interpretation

Note: Terms used in these Rules have the same meaning as in the Act. These terms include:

adult
complying health insurance policy
Council
general treatment
health benefits fund
hospital-substitute treatment
hospital treatment
medicare benefit
policy holder
private health insurer
risk equalisation levy
risk equalisation jurisdiction
Risk Equalisation Trust Fund
rules [of an insurer]

(1) In these Rules:

Act means the *Private Health Insurance Act 2007*.

age based pool or ***ABP*** has the meaning given by paragraph 7 (3) (a).

adjustment amount means an amount calculated under Part 4.

benefit paid means a benefit paid by an insurer, in accordance with a policy, to or on behalf of an insured person covered by that policy.

Business Rules means the *Private Health Insurance (Health Insurance Business) Rules 2007* made under the Act.

designated threshold means the threshold specified in subrule 7 (10).

eligible benefit has the meaning given by subrule 5 (1).

Fund means the Risk Equalisation Trust Fund.

gross benefit means the total eligible benefits paid by the insurer in respect of an insured person who falls within an age cohort set out in the table in subrule 7 (5).

hospital policy means a policy which covers any hospital treatment.

insured person means a person who receives the treatment to which the eligible benefit paid by the insurer to a policy holder relates.

insurer means a private health insurer.

levy means risk equalisation levy.

Levy Act means the *Private Health Insurance (Risk Equalisation Levy) Act 2003*.

policy means a complying health insurance policy.

Principles means the *Health Benefits Reinsurance (Trust Fund Principles) Determination 1998* made under the *National Health Act 1953,* and as in force immediately before the commencement of the Act.

quarter means a period of 3 months ending on 31 March, 30 June, 30 September or 31 December in a year and in respect of calculation of amounts under these Rules means the quarter to which the calculation relates.

quarterly return has the same meaning as in the Risk Equalisation Administration Rules.

Risk Equalisation Administration Rules means the *Private Health Insurance (Risk Equalisation Administration) Rules 2007* made under the Act.

risk equalisation levy day has the same meaning as in the *Private Health Insurance (Risk Equalisation Levy) Act 2003*.

single equivalent unit for a policy means the number determined in accordance with rule 4.

State is taken to mean an area specified as a risk equalisation jurisdiction in the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007* made under the Act.

Note: The risk equalisation jurisdictions are the Northern Territory; New South Wales and the Australian Capital Territory; Western Australia including the Territory of Christmas Island and the Territory of Cocos (Keeling) Islands; and each of the other States.

(2) In these Rules, if a quarter that falls within the term ***preceding 3 quarters*** is a quarter that occurred before 1 April 2007 that quarter is not to be taken into account in the calculation to which the term relates.

Note: Example - For the quarter ending on 30 June 2007, the 3 preceding quarters were before 1 April 2007. Therefore, the calculation will not take account of any of those preceding quarters. For the quarter ending on 30 September 2007 the calculation will only take into account the preceding quarters after 1 April 2007 (ie, the quarter ending on 30 June 2007) and for the quarter ending on 30 December 2007, the calculation will take into account the quarters ending on 30 June and 30 September 2007.

4. Single equivalent unit

(1) If a policy falls into one of the categories of policies specified in subrule (2), the single equivalent unit for the policy is the number shown next to the category in that subrule.

(2) The categories of policies, and single equivalent unit for each category, are

(a) a hospital policy under which only one person is insured—1;

(b) a hospital policy under which 2 adults are insured (and no-one else)—2;

(c) a hospital policy under which 2 or more people are insured, none of whom is an adult—1;

(d) a hospital policy under which 2 or more people are insured, only one of whom is an adult—1;

(e) a hospital policy under which 3 or more people are insured, only 2 of whom are adults—2;

(f) a hospital policy under which 3 or more people are insured, at least 3 of whom are adults—2.

Note: Hospital policy means a policy which covers any hospital treatment—see subrule 3 (1).

5. Eligible benefits

(1) ***Eligible benefit*** means a benefit paid by an insurer under a policy for any of the following:

Note: Policy means a complying health insurance policy—see subrule 3 (1).

(a) the following components of general treatment provided as part of a chronic disease management program:

(i) the planning and coordination services described in paragraphs (b) and (c) of the definition of chronic disease management program in the Business Rules; and

(ii) allied health services, as defined in the Business Rules, which are provided as part of the chronic disease management program;

(b) hospital-substitute treatment;

(c) hospital treatment, other than treatment provided as part of a chronic disease management program, or a program of a similar type in respect of a person with a chronic disease, except as mentioned in paragraph (d); and

(d) the following components of hospital treatment that are part of a chronic disease management program that is intended to reduce complications in a person with a diagnosed chronic disease:

(i) the planning and coordination services described in paragraphs (b) and (c) of the definition of chronic disease management program in the Business Rules; and

(ii) allied health services, as defined in the Business Rules, which are provided as part of the chronic disease management program.

(2) In this rule, the following terms have the same meaning as in the Business Rules:

chronic disease management program

chronic disease

risk factors for chronic disease

Note1 : The Business Rules exclude some classes of treatment from the definition of hospital treatment.

Note 2: Health insurance benefits are not payable for any treatment for chronic disease management for which a medicare benefit is payable—see section 121-10 of the Act.

(3) For the avoidance of doubt, benefits not covered by paragraphs (1) (a) and (1) (d) include benefits paid for any other treatment as part of a chronic disease management program including, but not limited, to:

(a) diagnosis of chronic disease;

(b) the identification of risk factors.

Part 2 Calculation of levy

6. Purpose of this Part

For paragraph 318-10 (2) (b) of the Act, this Part specifies the method for working out the amount of levy, in respect of each health benefits fund of an insurer, to be paid by each insurer as risk equalisation levy.

7. Matters to be taken into account

(1) The matters mentioned in this rule are to be taken into account on a State-by-State basis consistently with the information provided by the insurer in its quarterly return for a fund for a State.

(2) The amount of levy for a quarter for an insurer, for each health benefits fund of that insurer, is to be calculated having regard to:

(a) the age of each insured person in respect of whom an eligible benefit is paid in that quarter; and

(b) the mean number for that quarter of single equivalent units for that fund, being the number determined by adding the number of such units on the last day of the previous quarter and the number of such units on the last day of the quarter for which the levy is being calculated, and halving the result; and

(c) the amount of eligible benefit paid in that quarter and in the preceding 3 quarters; and

(d) any adjustment amount.

(3) To calculate the amount of levy in respect of a current quarter:

(a) an amount calculated in accordance with subrule (4) is first to be notionally allocated to a pool called the age based pool (***ABP***); and

(b) 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 a pool called the high cost claimants pool (***HCCP***).

(4) The amount to be notionally allocated to the ABP in a quarter is to be calculated in accordance with the formula pC, where:

(a) **p** is the percentage of the eligible benefit paid having regard to the age cohort, as specified in the table in subrule (5), into which the insured person falls on the day or days on which the insured person receives the treatment to which the eligible benefit relates; and

(b) **C** is the gross benefit in the current quarter.

(5) The age cohorts are as specified in the following table:

Age cohorts	
Age	**% of eligible benefits included in pool**
0-54	0.0%

Age cohorts	
Age	**% of eligible benefits included in pool**
55-59	15%
60-64	42.5%
65-69	60%
70-74	70%
75-79	76%
80-84	78%
85+	82%

(6) Where an insured person receives treatment over a number of days such that the age of the insured person on the day or days on which that person receives the treatment falls within more than one age cohort, 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.

Note: For example, Mr X, a 59-year-old insured person whose birthday is on 24 January is admitted to hospital on January 19. Mr X is discharged from the hospital on 29 January. Mr X's gross benefit is $10,000. In this case, as half the time in which Mr X was receiving treatment was spent while he was 59 years old and the other half while he was 60 years old, the amount to be notionally allocated to the ABP will use the rates in both the 55-59 and the 60-64 age cohorts. Therefore, the amount notionally allocated to the ABP will be: 0.5*$10,000*15%+0.5*$10,000*42.5% which equals $2,875.

(7) An amount is to be notionally allocated to the HCCP for a current quarter in respect of an insured person if:

(a) an amount has been notionally allocated to the ABP pursuant to subrule (4); and

(b) the total gross benefit for the current and the immediately preceding 3 quarters less the amount notionally allocated to the ABP under subrule (4) in the current and preceding 3 quarters exceeds the designated threshold.

(8) The amount to be notionally allocated to the HCCP is to be calculated in accordance with the formula m(R-T) - H, where:

(a) **m** is 82%;

(b) **R** is the total gross benefit for the current and the preceding 3 quarters less the amount notionally allocated to the ABP under subrule (4) in the current and preceding 3 quarters;

(c) **T** is the designated threshold;

(d) **H** is the sum of the amounts notionally allocated to the HCCP in the preceding 3 quarters.

Note: Example 1: Mr X is 63 and has a gross benefit of $100,000. In this case, the amount that will be notionally allocated to the ABP is $42,500 (42.5% * $100,000). Assuming that Mr X has not made a previous claim in the preceding 3 quarters, Mr X will be above the $50,000 threshold. That is, $57,500 (the amount not notionally allocated to ABP in the current quarter with no other claims in the preceding 3

quarters) exceeds the designated threshold of $50,000. Here, the amount that will be notionally allocated to the HCCP is $6,150 (82% * ($57,500 - $50,000) - 0). As there are no gross benefits in the preceding 3 quarters, the only amount that was not allocated to the ABP is the amount in the current quarter (ie, $100,000 - 42,500 = $57,500) and the amount notionally allocated to the HCCP in the preceding 3 quarters is zero.

Example 2: Assuming that, in the next quarter, Mr X has another gross benefit of $100,000 and is still 63, the amount to be notionally allocated to the ABP will be the same as in the previous example. That is, the amount allocated to the ABP will be $42,500. The calculation of the total amount not notionally allocated to the ABP will need to account for the previous claim amount in Example 1 for the purposes of calculating whether the total amount not allocated to the ABP exceeds the designated threshold. In this case, the total residual amount will be $115,000 ($57,500 (amount not allocated in the ABP in the previous quarter) + $57,500 (amount not allocated in the ABP in the current quarter). The result is that the total amount not allocated to the ABP in the current quarter and in the preceding 3 quarters of $115,000 exceeds the designated threshold of $50,000. Subject to the limit in subrule (9), the amount to be notionally allocated to the HCCP in this case will be $47,150, which represents 82% of the difference between the sum of the total amount not allocated to the ABP in the current and in the preceding 3 quarters ($57,500 + $57,500) and the threshold ($50,000), minus the sum of the amount notionally allocated to the HCCP in the preceding 3 quarters (in this case, as there was only one amount in the previous quarter, the sum is $6,150).

(9) Where the amount notionally allocated to the HCCP under subrule (7) exceeds (m-p)C where:

(a) **m** is 82%;

(b) **p** is the percentage of the eligible benefit paid having regard to the age cohort set out in the table in subrule (5) into which the insured person falls on the day or days on which the insured person receives the treatment to which the eligible benefit relates;

(c) **C** is the gross benefit in the current quarter,

then the amount notionally allocated to the HCCP will be the amount calculated using the formula (m-p)C.

Note In the case of example 2 under subrule (7) above, the amount allocated to the HCCP is $47,150. The maximum under subrule (9) that can be notionally allocated is $39,500 ($100,000 (the gross benefit) multiplied by 0.82 (the HCCP percentage) minus 0.425 (the ABP cohort percentage)). As the maximum calculated using (m-p)C of $39,500 is less than $47,150, the amount to be notionally allocated to the HCCP will be $39,500.

(10) For the purposes of these Rules, the designated threshold for an insured person is $50,000.

8. Payments by former insurer

Where:

(a) an insurer (***former insurer***) has paid an amount of eligible benefit in respect of an insured person; and

(b) the insured person ceases to be covered by a policy of the former insurer and becomes covered by another insurer,

the amount of eligible benefit paid is to continue to be treated as a payment by the former insurer.

9. Payments where a health benefits fund is transferred

(1) Where:

(a) an insurer has paid an eligible benefit; and

(b) the health benefits fund of that insurer is transferred to another fund, whether of that insurer or another insurer (***receiving fund***), resulting in the policy under which the benefit was paid becoming referable to another fund,

the eligible benefit paid is to be treated as a benefit paid in respect of the receiving fund.

(2) Where:

(a) an insurer has paid an amount of levy on the basis of the eligible benefit paid by a health benefits fund of that insurer; and

(b) that health benefits fund is transferred to another fund, whether of that insurer or another insurer (***receiving fund***), resulting in the policy under which the benefit was paid becoming referable to another fund,

the levy paid is to be treated as a levy in respect of the receiving fund.

10. Effect of unpaid premiums

If the premiums for a policy have not been paid for a period longer than:

(a) 2 months after the end of the period for which premiums were last paid; or

(b) if the rules of the insurer allow a longer period—that longer period; and

(c) the insurer has given written notice to the person in whose name the policy is held that the policy is no longer in operation (***terminated policy***),

a single equivalent unit is not to be taken into account for that terminated policy in determining the mean number referred to in paragraph 7 (2) (b) for the insurer's health benefits fund.

11. Method of calculation

(1) The following method is to be applied in calculating the amount (if any) of levy for each health benefits fund of an insurer (***Insurer Z***) for a particular quarter in respect of a State:

(a) calculate, for each fund, the amount that is the sum of:

(i) the total amount of the eligible benefits notionally allocated for the quarter in that State to the ABP, as mentioned in subrule 7 (4); and

(ii) the total amount of the eligible benefits notionally allocated for the quarter in that State to the HCCP, in accordance with subrule 7 (7) or, if applicable, subrule 7 (9);

(b) add the amounts calculated under paragraph (a) for each fund to obtain a total for the State;

(c) ascertain the number that is the total of the average number of single equivalent units in that State for the quarter for all funds by:

(i) determining, under paragraph 7 (2) (b), the mean number of single equivalent units for each fund in the State; and

(ii) adding the number determined under subparagraph (i);

(d) calculate the average amount payable for each single equivalent unit by dividing the total amount determined under paragraph (b) by the total number ascertained under paragraph (c);

(e) calculate the total amount that would have been payable by Insurer Z in respect of the fund if the single equivalent units determined under paragraph 7 (2) (b) to be the mean number of single equivalent units in that State for the fund had each been entitled to the amount calculated under paragraph (d) by multiplying the amount calculated in (d) by the mean number of single equivalent units for Insurer Z as calculated in (c) (i);

(f) calculate the difference between the amount calculated under paragraph (e) and the amount calculated under paragraph (a) for Insurer Z.

(2) 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.

(3) Where an insurer fails to provide a quarterly return to the Council that is necessary to enable the Council to carry out the calculation referred to in this rule, the Council must carry out the calculation using the quarterly return last provided by the insurer for the relevant quarter and State.

12. Calculation of rate of levy

(1) Subject to subrule (2), if the amount calculated under paragraph 11 (1) (a) for an insurer is less than the amount calculated under paragraph 11 (1) (e), having taken into account any adjustment amount, the rate of risk equalisation 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.

(2) If an insurer conducts more than one health benefits fund in one or more States, the rate of levy for that insurer is to be 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

For paragraph 318-10 (2) (a) of the Act, this Part specifies the method for working out the amounts to be paid out of the Fund to insurers.

14. Matters to be taken into account

(1) 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 equalisation levy.

(2) Rule 10 has the same application to this rule as it has to rule 7.

15. Method of calculation

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

(1) Subject to subrule (2), if the amount calculated under paragraph 11 (1) (a) for an insurer is more than the amount calculated under paragraph 11 (1) (e), having taken account of 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.

(2) If an insurer conducts more than one health benefits fund in one or more State, 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

(1) Subject to subrule (2), 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.

(2) 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.

(3) 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.

(4) The Council may pay any amount of non-levy in the Fund to insurers, but such a payment must be made simultaneously to all insurers and must be determined proportionally for each insurer in accordance with the number of single equivalent units of that insurer in the quarter immediately before the payment is made.

(5) In subrule (4), ***non-levy*** 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'

In this Part, 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 out of the Fund

(1) If a calculation (the ***primary calculation***) was made of the amount calculated as levy or an amount paid out of the Fund to an insurer for a quarter:

(a) under rule 11 or 16; or

(b) under section 2.6 or 3.3 of the Principles,

and the Council receives information (***new information***) on a matter mentioned in subrule 7 (2) or subsection 2.2 (1) of the Principles, as the case may be, 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 account of the new information.

(2) Unless subrule (3) applies, a new calculation may only be made if the new information is received by the Council:

(a) during or by the end of the first quarter following the financial year in which the particular quarter concerned occurs; or

(b) within the period provided under subsection 169-5 (1) of the Act for the giving of the report, described in that subsection, that relates to the particular quarter concerned.

(3) A new calculation may be made as a result of new information received later than is allowed under subrule (2) if the Council is satisfied that:

(a) the new information demonstrates that, in preparing its report in respect of information that the Council is required to acquire under section 169-5 (1) of the Act, the insurer made a significant error; and

(b) it is in the best interests of insurers generally, and good administration of the Fund, that a further calculation be made.

Note: Example 1: Under subrule (2), new information could be considered for a calculation made for the September quarter of 2007 if the new information was received by the Council at any time until, and including, 30 September 2008 (unless the Council permitted a longer period for the giving of the information required by section 169-5). This is because the insurer concerned has until the end of September 2008 to give the Council audited information to enable the Council to prepare its report to the Minister about the 2007-08 financial year (see subsection 169-5 (1) and section 264-15 of the Act).

Example 2: Under subrule (3), new information could not be considered for a calculation made for the June quarter of 2008 if the

information was received by the Council after 30 September 2008 (unless the Council permitted a longer period for the giving of the report required by section 169-5). This is because 30 September 2008 was the last day for the Council to receive information about the insurer's operations in the 2007-08 financial year to enable it to prepare its report to the Minister (see subsection 169-5 (1) of the Act).

(4) Where a new calculation is made under subrule (1) in relation to a primary calculation made under section 2.6 or 3.3 of the Principles, the new calculation must be made in accordance with the Principles as in force before the commencement of the Act.

Note: The effect this subrule is that a new calculation in respect of the March quarter 2007 and any other prior quarter is to be made in accordance with the Principles no matter when the new calculation is made.

20. Application of new calculation to determine adjustment amount

(1) 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 (3) applies.

(2) The Council must determine the adjustment amount by having regard to the difference between the amount paid as levy 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.

(3) If the Council is satisfied that:

(a) 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

(b) 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 taken into account in that quarter,

the Council may determine that an adjustment amount in respect of a particular insurer or particular insurers is to be applied over such number of quarters (proportional, or as otherwise decided by the Council) as the Council determines to be reasonable.

(4) In this rule:

unreasonably affected means:

(a) in the case of an insurer, if a new calculation is made under this Part and the adjustment amount was to be taken into account under rule 13 in one quarter, the financial stability of the insurer would, in the opinion of the Council, be at risk; or

(b) 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.

Note

1. All legislative instruments and compilations are registered on the Federal Register of Legislative Instruments kept under the *Legislative Instruments Act 2003*. See www.frli.gov.au