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 (No.3)

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 of the Act, or necessary or convenient in order to carry out or give effect to the Act.

The *Private Health Insurance (Complying Product) Rules 2007(No.3)* (the Rules) commence on the day following registration on the Federal Register of Legislative Instruments.

The Rules revoke and replace the *Private Health Insurance (Complying Product) Rules 2007 (No.2)* (the previous Rules).

Transitional rule 17 of the Rules provides that the Schedules to the previous Rules continue to have effect in place of the Schedules to the new Rules until 7 December 2007. This is to allow private health insurers time to adjust to changes to Standard Information Statement (SIS) requirements.

The Rules make changes to rule 5 (Insured groups), rule 7 (Benefits authorised to be provided under a policy), and to portions of the Rules relating to Standard Information Statements. The Rules also insert a new rule 8A (Benefit requirement – nursing-home type patients).

Rule 5 specifies the insured groups for the purpose of paragraph 63-5(2A)(b) of the Act. Rule 5 of the Rules differs from the previous Rules by the insertion of new classifications of non-student policies, and certain other policies that cover dependent child non-students with respect to insured groups. The purpose of the change is to add two new sets of insured groups for a transitional period.

Rule 8A of the Rules is a new insertion made under paragraph 72(1)(b) of the Act. Its purpose is to enforce the patient contribution for privately insured nursing-home type patients by restricting the amount of benefit that private health insurers pay under each policy for each day of NHTP hospital treatment at a hospital to the hospital's charge less the patient contribution amount.

As part of the introduction of the Act on 1 April 2007, the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* inadvertently repealed Schedule 1, paragraph (1)(e) of the *National Health Act 1953* which previously enforced the non insurable patient contribution for private NHTPs.

The patient contribution will continue to also be determined pursuant to subsection 3(1) of the *Health Insurance Act 1973* as it continues to apply in relation to public patients via the *2003-2008 Australian Health Care Agreements.*

Technical amendments to portions of the Rules dealing with Standard Information Statements have been made to provide additional permitted options to allow insurers to complete Standard Information Statements (SISs) more accurately, including a new field which will display whether or not each product provides the insured with an exemption for the Medicare Levy Surcharge.

Consultation

The Department conducted consultation with the private health insurance industry and the Private Health Insurance Administration Council on the changes to insured groups. An Exposure Draft on the proposed changes to insured groups was released to the industry on 18 October 2007. A further draft was circulated to the industry for their comment on 19 November 2007.

Consultation was not necessary in respect to rule 7, NHTP and SIS changes as those changes are machinery in nature and do not substantially alter existing arrangements.

The Act does not specify any condition which needs 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*.

ATTACHMENT

DETAILS OF THE *PRIVATE HEALTH INSURANCE (COMPLYING PRODUCT) RULES 2007 (No.3)*

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(No.3)*

2. Commencement

Rule 2 provides that the Rules are to commence on the day following registration on the Federal Register of Legislative Instruments.

The Note to rule 2 indicates that rule 17 defers the effect of the Schedules to 7 December 2007.

3. Revocation

Rule 3 provides for the *Private Health Insurance (Complying Product) Rules 2007 (No.2)* to be revoked.

The Note to rule 3 indicates that rule 17 gives continuing effect to the Schedules in those Rules until 7 December 2007.

4. Definitions

Rule 4 provides that terms used in the Rules have the same meaning as in the Act. Rule 4 also defines specific terms used in the Rules.

PART 2 - General

5. Insured groups

Rule 5 provides for the purposes of paragraph 63-5 (2A) (b) of the Act, insured groups.

Subrule 5(1)(a) sets out the insured groups for policies other than a non-student policy or a policy referred to in paragraph (c).

Subrule 5(1)(b) sets out the composition of insured groups for policies that are a non-student policy.

Subrule 5(1)(c) sets out the composition of insured groups for policies that before 31 December 2008 covered a dependent child non-student but require the dependent child non-student to have his or her own policy with the insurer for general treatment (other than hospital-substitute treatment).

Subrule 5(2) defines the term ***dependent child non-student*** as being a person who is aged between 18 and 24, was born before 1991, is a dependent child under the rules of the insurer that insures the person, does not have a partner, is not receiving full-time education at a school, college or university.

Subrule 5(2) also defines the term ***non-student policy*** as a health insurance policy that is issued before 31 December 2008 and at any time before 31 December 2008 covers one or more dependent child non-student. The premium for the policy is:

(i) less than the amount worked out under paragraph (3)(a); and
(ii) more than the amount worked out under paragraph (3)(b).

Subrule 5(3) sets out the formula for calculating premiums for the purposes of a 'non-student policy'.

Subrule 5(3)(a) provides that, for the definition of 'non-student policy', work out the premium that would apply under the relevant product subgroup by reference to the relevant insured group in paragraph 5(1)(a), as indicated subparagraphs 5(3)(a)(i) to(iv).

Subrule 5(3)(a)(i) provides that if the policy covers one adult only, one or more dependent child non-student and any other dependent child, a premium is worked out by adding together the premiums for the insured groups in subparagraphs 5(1)(a)(i) and (iv).

Subrule 5(3)(a)(ii) provides that if the policy covers one adult only, one or more dependent child non-students and no other dependent child, a premium is worked out by adding together the premiums for the insured groups in subparagraphs 5(1)(a)(i) and (ii).

Subrule 5(3)(a)(iii) provides that if the policy covers two adults, one or more dependent child non-student and one or more other dependent child, a premium is worked out by adding together the premiums for the insured groups in subparagraphs 5(1)(a)(i) and (v).

Subrule 5(3)(a)(iv) provides that if the policy covers two adults, one or more dependent child non-student and no other dependent child, a premium is worked out by reference to the insured group in subparagraph 5(1)(a)(vi), or, if the insurer does not cover this type of insured group, by adding together the premiums for the insured groups in subparagraphs 5(1)(a)(i) and (ii).

Subrule 5(3)(b) provides that for the definition of 'non-student policy' work out the premium that would apply under the relevant product subgroup determined by reference to the relevant insured group in paragraph 5(1)(a) if any dependent child non-student covered under the policy was treated as a dependent child who is not a dependent child non-student.

6. Maximum percentage of discount

Rule 6(1) provides that the maximum percentage discount allowed under section 66-5 (1)(c)(ii) of the Act is 12% per annum.

Rule 6(2) provides that the discount for a policy is the difference between the full premium and the net premium.

Rule 6(3) provides that a full premium for a policy is the premium that would be received by the private health insurer for a policy in the same product subgroup 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 6(4) provides that the net premium is the full premium less any cost listed in the Rules such as incentive payment, promotional payment or any other inducement.

Rule 6(5) excludes from the calculation of net premium in Rule 6(4) a brokerage fee or other commission paid in respect of the policy.

Rule 6(5) also excludes from the calculation of net premium in Rule 6(4) a one-off promotional offer provided the cost of the one-off promotional offer does not exceed 12% of the full premium, for a year, of the policy purchased. The promotion must be offered to a person at the time the person first purchases a policy from the insurer, and the promotion must be provided in the first year after the person purchases the policy.

7. Benefits authorised to be provided under a policy

Rule 7(1) provides that ***specified benefit*** means a benefit specified in subrule 7 (3).

Rule 7(2) provides that if a person was entitled to a specified benefit as listed in subrule 7 (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 authorised for the purpose 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 specified benefits.

The previous rule provided for the grandfathering of funeral, birth and disability benefits where the policy provides the same "*specified treatment and the same benefits*". The addition of the word "*specified*" clarifies that where a change is made to the benefits regarding funeral, birth or disability benefits, this will end the grandfathering arrangements.

Rule 7(3) provides that specified benefits for Rule 7 are benefits paid in connection with the birth of a baby, funeral benefits, and disability benefits.

Rule 7(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.

8. 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 authorised 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 8(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.

Rule 8(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 8(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.

8A Benefit requirement – nursing-home type patients

Subrule 8A(1) provides that for paragraph 72-1(1)(b) of the Act the requirement in subrule 8A(2) is a benefit requirement for a policy that covers hospital treatment.

Subrule 8A(2) is an equivalent requirement to the repealed Schedule 1, paragraph (1)(e) of the *National Health Act 1953.* It enforces the patient contribution for privately insured NTHPs by restricting the amount of benefit that private health insurers can pay under each policy for each day of NHTP hospital treatment at a hospital to the hospital's charge less the patient contribution amount.

Subrule 8A(3) provides that a NHTP in these Rules has the same meaning as a NHTP in the *Private Health Insurance (Benefit Requirement) Rules,* and defines patient contribution for the purpose of subrule 8A.

Subrule 8A(3)(a) sets the patient contribution amount for privately insured patients in public hospitals in each State or Territory. The current patient contribution for a NHTP at a public hospital in Australian Capital Territory is $38.20, New South Wales is $38.40, Northern Territory is $39.05, Queensland is $39.05, South Australia is $39.05, Tasmania is $39.05, Victoria is $39.05 and Western Australia is $39.05.

Subrule 8A(3)(b) sets the patient contribution amount for privately insured patients in private hospitals. The patient contribution for a NHTP at a private hospital is $39.05.

9. Waiting periods – former gold card holders

Rule 9 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 9(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 9(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 9(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.

10. Transfer certificates

Rule 10 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.

11. Performance indicators

Rule 11 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

12. Definitions

Rule 12 defines specific terms used for the purpose of this Part.

13. Information and form

Rule 13(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 13(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.

The changes to Rule 13 made by these Rules are to insert in subrule 13(2) permission for insurers to place a barcode or product code in the margin of the SIS, and for insurers to omit the 'Medicare Levy Surcharge' field until 1 April 2008. The 'Medicare Levy Surcharge' field is inserted by these Rules.

Rule 13(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.

14. Policies covering hospital treatment only

Rule 14 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.

15. Policies covering general treatment only

Rule 15 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.

16. Policies covering hospital and general treatment

Rule 16 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.

17. Transitional period

Rule 17 provides that until 7 December 2007 the Schedules in the *Private Health Insurance (Complying Product) Rules 2007 (No.2)* remain in effect, and not the Schedules to these Rules.

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.

Schedules 1, 2 and 3 now include the addition of a "Medicare Levy Surcharge" field beneath the "Monthly Premium" field.

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.

The following changes to Schedule 4 are made by these Rules.

Schedule 4, Part 1 has been corrected to amend the spelling of "dependents" to "dependants" in the "Who is covered" field.

Schedule 4, Part 1 includes a 'Medicare Levy Surcharge' field, and a 'product code' field.

Schedule 4, Part 2 includes a new field "[If available with general treatment policy only]". This field is to cater for "mix and match" combined policies where the hospital component cannot be purchased on its own, but can be combined with more than one general treatment policy. The reverse situation is already catered for in Schedule 4, Part 3, however the wording of the permitted content has been amended to say "must be purchased…" instead of "can only be purchased…".

Schedule 4, Part 2 provides a new option "hip replacements" under the "What medical services are not covered at all?" and the "What medical services are only covered to a limited extent?" fields. This option is available for both restrictions and benefit limitation periods.

Schedule 4, Part 2 provides a new rule under the "Extra Cost per day (co-payments)" field which instructs insurers to delete the field relating to co-payments in a private room if the policy does not cover accommodation in a private room.

Schedule 4, Part 2 contains a new option for the "Doctors' and Hospital Bills" field stating "gap cover benefit figures are not yet available" to cater for new health insurers who do not have any gap cover statistics to put on the SIS.

Schedule 4, Part 3 no longer requires insurers to add the words "see insurer for details" when using the "other services" option under the 'Benefit Limits (per 12 months)' column' field.

PRIVATE HEALTH INSURANCE BRANCH
DEPARTMENT OF HEALTH AND AGEING
NOVEMBER 2007