EXPLANATORY STATEMENT

Issued by Authority of the Minister for Health and Ageing

Private Health Insurance Act 2007

Private Health Insurance (Benefit Requirements) Rules 2011

Section 333-20 of the *Private Health Insurance Act 2007* (the PHI Act) provides that the Minister may make *Private Health Insurance (Benefit Requirements) Rules* providing for matters required or permitted by Part 3-3 of the Act, or necessary or convenient in order to carry out or give effect to Part 3-3 of the Act.

The *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules) revoke and remake the *Private Health Insurance (Benefit Requirements) Rules 2010)* (as amended), and commence on 1 November 2011, or if registered after 1 November 2011, the day after registration.

The Rules insert Part 2, Rule 6 and amend Schedules 1, 3, 4 and 5.

The Rules provide for the minimum benefit requirements for psychiatric care, rehabilitation, palliative care and other hospital treatment. Schedules 1 to 5 to the Rules set out the minimum levels of benefit which are payable for hospital treatment. Namely, benefits for overnight accommodation (Schedules 1 and 2), same day accommodation (Schedule 3), nursing-home type patients (Schedule 4), and second tier default benefits (Schedule 5).

The purpose of the insertion of Part 2 Rule 6 is to enable hospitals to charge, and insurers to pay, an amount below the minimum benefit level for psychiatric, rehabilitation and palliative care. The intended effect of the amendment is to provide improved flexibility to industry and lower health cost outcomes to consumers.

The purpose of the amendment to Schedule 1, clauses 7 and 8 of the Rules is to clarify the definitions of psychiatric patients and rehabilitation patients which apply to private patients in a public hospital in Victoria and Tasmania, and in private hospitals nationally. The Department has been made aware that the current definitions of psychiatric and rehabilitation patients have led to conflicting interpretations by insurers and hospitals. The intended effect of Clauses 7 and 8 of Schedule 1 of the Rules is that the payment of a higher level of hospital accommodation benefits, for patients undergoing psychiatric or rehabilitation treatment, is subject to health insurer approval of a particular treatment program and the relevance to the patient diagnosis. Some insurers have determined the suitability of a program by facility rather than program content. Alternatively, some hospitals have interpreted that if they meet an insurer's standards for a program, the insurer must pay the benefit in any circumstance. The amendment clarifies that the decision by the insurer must be related to the patient's disease, injury or condition and the relevance and quality of the treatment program.

The purpose of the amendments to Schedule 1, subclauses 4(3) and 6(3) and Schedule 3, clause 8 of the Rules is to reflect changes in the Medicare Benefits Schedule (MBS) commencing on 1 November 2011. The list of Medicare Benefits Schedule (MBS) item numbers which attract same day hospital accommodation benefits in Schedule 3, clause 8 of the Rules is updated by adding two new item numbers (32520 and 32522) and deleting one existing item number (2710). Subclause 6(3) of Schedule 1 of the Rules is amended to delete two existing item numbers (35400 and 35402) which attract overnight hospital accommodation benefits. Additionally, subclauses 4(3) and 6(3) of Schedule 1 are amended to specify that patients will be classified as 'Surgical patients' when undergoing procedures

with a MBS fee within a threshold range of $249.26 to $837.05, and will be classified as 'Advanced surgical patients' when undergoing procedures with a MBS fee greater than $837.05. These amounts are increased by 2% to align with indexation that will apply to MBS Schedule fees from 1 November 2011. Schedule 3, clause 8 of the Rules is also updated to include an additional nine MBS item numbers (69415, 16501, 16502, 16504, 16505, 16508, 16509, 16511, and 289) that were inadvertently excluded from the Rules in the past.

The purpose of the amendments to Schedule 4, clause 6 of the Rules is to increase the minimum benefits payable per night for nursing-home type patients (NHTPs) at public hospitals in the Northern Territory.

The purpose of the amendments to Schedule 5, clause 4 of the Rules is to remove two facilities from the list of Second Tier default benefit facilities following notification of their closure. These changes reduce the number of listed facilities from 363 to 361.

Consultation

Part 2

The amendments to Part 2 Rule 6 have been made after this matter was raised by insurers. The Department has considered this issue and the current amendments are being made in response.

Schedule 1, clauses 7 and 8

The ambiguity of the wording of clauses 7 and 8 in Schedule 1 was raised by hospitals and insurers. The Department has considered this issue and the current amendments are being made in response. The Victorian Department of Human Services, Eastern Health Victoria, and private health insurers were consulted in writing and by telephone in respect of these changes. No further consultation was undertaken because the amendments are minor in nature and do not result in additional costs for treatment.

Schedule 1, clauses 4 and 6 and Schedule 3, clause 8

New items are added to the MBS and existing items are amended or omitted because the medical services in the MBS are constantly reviewed to ensure that they are up-to-date, comprehensive and representative of best medical practice. This review process is undertaken by the Medical Services Advisory Committee, which provides independent advice to the Minister for Health and Ageing. In addition, the South Australian Department of Health drew the Department's attention to MBS item numbers which had inadvertently been omitted from the Rules in the past. The Department has also sought medical advice about the proposed amendments. The changes to Schedules 1 and 3 of the Rules are necessary to ensure that private health insurers pay the minimum benefit for insured persons that receive hospital treatment corresponding to one of the new MBS item numbers, in a hospital where that private health insurer does not have a contractual agreement with that hospital.

Schedule 4

On 30 August 2011, the Department advised the States and Territories of the increase in the Adult Pension Basic Rate and maximum daily rate of rental assistance and asked the jurisdictions to advise if they would be increasing their NHTP contribution and accommodation rates as a result. Queensland, South Australia and Tasmania responded to the Department confirming their new NHTP accommodation rates, which were incorporated in the *Private Health Insurance (Benefit Requirements) Amendment Rules 2011 (No. 8)*, effective 20 September 2011. The Northern Territory provided late confirmation of its new NHTP rates on 20 September 2011. Western Australia and Victoria also advised of their

intention to increase their NHTP contribution and accommodation rates at a later date yet to be determined.

Schedule 5

The Department was advised of the closure of two Second Tier eligible facilities. No consultation was undertaken in relation to the removal of two facilities from the table in clause 4 of Schedule 5 as the amendment is minor in nature.

PRIVATE HEALTH INSURANCE BRANCH
DEPARTMENT OF HEALTH AND AGEING
NOVEMBER 2011

ATTACHMENT

DETAILS OF THE *PRIVATE HEALTH INSURANCE (BENEFIT REQUIREMENTS) RULES 2011*

Part 1 Preliminary

1. Name of Rules

Rule 1 provides that the title of the Rules is the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules).

2. Commencement

Rule 2 provides that the Rules are to commence on 1 November 2011, or if registered after 1 November 2011, the day after registration.

Rule 2 further provides that the Rules revoke the *Private Health Insurance (Benefit Requirements) Rules 2010*.

3. Definitions

Rule 3 defines specific terms used in the Rules.

Part 2 Minimum benefit requirements

4. Psychiatric care, rehabilitation and palliative care

Subrule 4(1) provides that the benefit payable under a policy for any part of hospital treatment that is psychiatric care, rehabilitation or palliative care provided in a hospital with no medicare benefit payable for that part of the treatment, must be at least the amount set out, or worked out using the method set out, in Schedules 1, 2, 3, or 5 for that type of treatment.

Subrule 4(2) provides that despite subrule (1), the minimum benefit for the treatment may be reduced by the amount of any co-payment or excess that is required to be paid under the insured person's policy in respect of that treatment.

5. Other hospital treatments

Subrule 5(1) provides that if a policy covers any type of hospital treatment provided in a hospital, other than treatment referred to in rule 4, being treatment specified in either of Schedules 1, 2, 3, 4, or 5, it must provide at least the minimum benefit set out, or worked out using the method set out, in Schedules 1, 2, 3, 4, or 5 for that type of hospital treatment.

Subrule 5(2) provides that despite subrule (1), for hospital treatment, other than psychiatric care, rehabilitation and palliative care referred to in Part 2, Rule 4 if a negotiated agreement was in place between an insurer and an hospital where the treatment took place, the minimum benefit is the amount specified in the negotiated agreement.

Subrule 5(3) provides that despite subrules (1) and (2), the minimum benefit for the treatment may be reduced by the amount of any co-payment or excess that is required to be paid under the insured person's policy in respect of that treatment

6. Benefit not to exceed hospital fees or charges

Subrule 6(1) is a new subrule which provides that the benefit payable by the insurer in respect of hospital treatment for a person who is not a nursing-home type patient will not exceed the fees or charges incurred in respect of that hospital treatment.

Subrule 6(2) is a new subrule which provides that the amount of benefit payable by the insurer in respect of hospital treatment for a nursing-home type patient will not exceed the fees or charges incurred in respect of that hospital treatment less the amount of the patient contribution in relation to the patient for each day on which the patient was a patient in the hospital.

Schedule 1 – Overnight accommodation: private hospitals in all States/Territories and shared ward accommodation at public hospitals in Victoria and Tasmania

Part 1 - General

1. Circumstances

Clause 1 provides that Schedule 1 applies, where a policy covers a type of hospital treatment, and the treatment is provided to a patient who is not a nursing-home type patient, and the treatment:

- is provided to a patient at a private hospital or as shared ward accommodation at a public hospital in Victoria or Tasmania; and
- is provided for the purpose of permitting the provision to the patient of hospital treatment that is:
  - (i) a Type A procedure; and
  - (ii) for a period that includes part of an overnight stay.

Type A procedures are procedures specified in clauses 3 to 9, Part 2, Schedule 1 of the Rules. A Type A procedure also includes a certified Type B procedure or a certified overnight Type C procedure: definition of 'Type A procedure' in Rule 3 of Part 1 of the Rules.

2. Minimum benefit

Clause 2(1) provides that the minimum benefit for hospital treatment provided in the circumstances specified in this Schedule is the amount set out in Table 1, 2, or 3 in Schedule 1 for that hospital treatment (as applicable).

Clause 2(2) provides that days forming part of a continuous period of hospitalisation are to be counted when counting the days referred to in the tables in Schedule 1. Tables 1, 2, and 3 in Schedule 1 all refer to numbers of days as part of the method of working out the minimum benefit payable per night.

Part 2 Type A procedures

3. Interpretation

Clause 3 provides that a Type A procedure is a procedure specified in clauses 3 to 9, of Part 2, Schedule 1 of the Rules, provided to a patient in one of the categories of patients in clauses 4 to 9, Part 2, Schedule 1 of the Rules.

4. Advanced surgical patient

Clause 4(1) provides that in Schedule 1 the term ***advanced surgical patient*** has the meaning given by clause 4.

Clause 4(2) provides the situations when a patient is to be taken to be an advanced surgical patient upon admission to a hospital.

Clause 4(3) provides the item numbers in the MBS for the purpose of clause 4, but indicates that a listing in clause 4(3) only applies where an item has a fee in the MBS greater than $837.05.

5. Obstetric patient

Clause 5(1) provides that in Schedule 1 the term ***obstetric patient*** has the meaning given by clause 5.

Clause 5(2) provides the situations when a patient is taken to be an ***obstetric patient*** during an admission to a hospital.

Clause 5(3) provides that the item numbers specified in clause 5 are the item numbers in the general medical services table.

6. Surgical patient

Clause 6(1) provides that in Schedule 1 the term ***surgical patient*** has the meaning given by clause 6.

Clause 6(2) provides the situations when a patient is taken to be a ***surgical patient*** during an admission to a hospital.

Clause 6(3) provides the item numbers in the MBS for the purpose of clause 6, but indicates that a listing in clause 6(3) only applies where an item has a fee in the MBS within the range of $249.26 to $837.05.

These Rules delete MBS item numbers 35400 and 35402 from this clause.

7. Psychiatric patient

Clause 7 provides that in Schedule 1 the term ***psychiatric patient*** is deemed to be a patient admitted to a hospital for the purpose of undertaking a specific psychiatric treatment program that is deemed relevant and appropriate by the insurer.

The Note to this clause provides that if a patient is receiving psychiatric treatment that is not under a specific psychiatric treatment program, the patient is taken to be in the category of ‘other patient’.

These Rules clarify that the decision by the insurer about whether a patient is a psychiatric patient would be based on clinical reasons, related to the patient's illness/injury and the relevance and appropriateness of that program to treating the illness or injury.

8. Rehabilitation patient

Clause 8 provides that in Schedule 1 the term ***rehabilitation patient*** is deemed to be a patient admitted to a hospital for the purpose of undertaking a specific rehabilitation treatment program that is deemed relevant and appropriate by the insurer.

The Note to this clause provides that if a patient is receiving rehabilitation treatment that is not under a specific rehabilitation treatment program, the patient is taken to be in the category of ‘other patient’.

These Rules clarify that the decision by the insurer about whether a patient is a rehabilitation patient would be based on clinical reasons, related to the patient's illness/injury and the relevance and appropriateness of that program to treating the illness or injury.

9. Other patient

Clause 9 provides that in Schedule 1 the term ***other patient*** is deemed to be a patient at a hospital who is receiving any treatment that involves part of an overnight stay at a hospital, who is not an advanced surgical patient, surgical patient, obstetric patient, psychiatric patient, or rehabilitation patient.

The Note to this clause provides that a patient receiving hospital treatment that is palliative care as described in item 1 of the table in subsection 72-1(2) of the Act is deemed to be in the category of 'other patient'.

Part 3 Certified Type B procedures and certified overnight Type C procedures

10. Certified Type B procedures

Clause 10(1) provides that minimum benefits for overnight accommodation provided for in Schedule 1 are payable for patients receiving a Type B procedure only if certification under clause 10(2) is provided.

Clause 10(2) provides the requirements which must be satisfied in order for a Type B procedure to receive certification for hospital treatment for a period that includes part of an overnight stay at a hospital.

Type B procedures are procedures specified in clauses 3 to 7 of Schedule 3.

11. Certified overnight Type C procedures

Clause 11(1) provides that minimum benefits for overnight accommodation provided for in Schedule 1 are payable for patients receiving a certified Type C procedure only if certification has first been provided for the Type C procedure in accordance with clause 7 of Schedule 3 and certification under clause 11(2) is also provided.

Clause 11(2) provides the requirements, which must be satisfied for a certified Type C procedure to receive certification for hospital treatment for a period that includes part of an overnight stay at a hospital.

Type C procedures are procedures specified in clause 8 of Schedule 3. Certified Type C procedures are Type C procedures certified in accordance with clause 7 of Schedule 3.

Schedule 2 – Overnight accommodation: shared ward accommodation at public hospitals in the ACT, NSW, Northern Territory, Queensland, South Australia and Western Australia.

1. Circumstances

Clause 1 provides that Schedule 2 applies, where a policy covers a type of hospital treatment, and the treatment:

- is provided to a patient as shared ward accommodation at a public hospital in the ACT, NSW, Northern Territory, Queensland, South Australia, or Western Australia; and
- is provided to a patient who is not a nursing-home type patient; and
- is provided for the purpose of permitting the provision to the patient of hospital treatment that is:

(i) a Type A procedure; and

(ii) for a period that includes part of an overnight stay at a hospital.

Type A procedures are procedures specified in clauses 3 to 9, Part 2, Schedule 1 of the Rules. A Type A procedure also includes a certified Type B procedure or a certified overnight Type

C procedure, as set out in the definition of 'Type A procedure' in rule 3 of Part 1 of the Rules.

2. Minimum benefit

Clause 2(1) provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 1 of Schedule 2 is the amount set out in the table in Schedule 2.

Schedule 3 – Same-day accommodation: hospitals in all States/Territories

Part 1 - General

1. Circumstances

Clause 1 provides that Schedule 3 applies, where a policy covers a type of hospital treatment, and the treatment:

- is provided to a patient at a hospital; and
- is a Type B procedure; and
- does not include part of an overnight stay at a hospital.

Type B procedures are procedures specified in clauses 3 to 7 of Schedule 3. A Type B procedure also includes a certified Type C procedure as set out in the definition of 'Type B procedure' in Rule 3 of Part 1 of the Rules.

2. Minimum benefit

Clause 2(1) provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 1 of Schedule 3 is the amount set out in Table 1 or 2 of clause 2, Schedule 3.

Clause 2(2) provides for the meaning of references to 'Bands' in Tables 1 or 2 of clause 2, Schedule 3 (as applicable).

Part 2 – Type B procedures

3. Interpretation

Clause 3 provides that a Type B procedure is a procedure specified as a Band 1, 2, 3, or 4 as described in clauses 3 to 7, Part 2, Schedule 3.

Types of hospital treatment are classified into four specific bands and a non-specific band, based on the type of procedure and factors such as the type of anaesthetic used and theatre time.

4. Band 1

Clause 4 provides that for the purpose of the tables in clause 2 of Schedule 3, ***Band 1 treatment*** has the meaning given by clause 4.

Clause 4 provides that 'Band 1 treatment' is hospital treatment that involves a professional service of the type identified by the MBS item number specified in clause 4, or other treatment requiring day admission to a hospital that is not Band 2, 3 or 4 treatment.

Band 1 treatment includes specified category 3 therapeutic procedures and specified category 5 – diagnostic imaging services.

5. Non-band specific Type B day procedures

Clause 5(1) provides that hospital treatment that involves a professional service of the type identified by the MBS item number specified in clause 5 is a non-band specific Type B day procedure.

Clause 5(2) provides that a non-band specific Type B day procedure is Band 2, 3 or 4 treatment depending on anaesthetic type and where applicable, theatre times as specified in clause 6 of this Schedule.

Clause 5(3) provides that if a non-band specific Type B day procedure does not involve anaesthetic or theatre times, the minimum benefit is the benefit for Band 1 treatment.

6. Other bands

Clause 6 provides a definition of ***Band 2 treatment, Band 3 treatment and Band 4 treatment***.

7. Certified Type C procedure

Clause 7(1) provides that minimum benefits for day-only accommodation provided for in Schedule 3 are payable for patients receiving a Type C procedure only if certification under clause 7(2) is provided.

Clause 7(2) provides the requirements, which must be satisfied in order for a Type C procedure to receive certification for hospital treatment at a hospital for a period including 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.

Type C procedures are procedures specified in clause 8, Part 3 of Schedule 3.

Part 3 – Type C procedures

8. Interpretation

Clause 8 provides that a Type C procedure is a procedure specified in clause 8 by reference to MBS items.

These procedures normally do not require hospital treatment. Clause 8 specifies certain items in the general medical services table, the diagnostic imaging services table, the pathology services table and a few miscellaneous services.

These Rules insert MBS item numbers 289, 16501, 16502, 16504, 16505, 16508, 16509, 16511, 32508, 32511 and 69415, and delete item number 2710, from this clause.

Schedule 4 – Nursing-home type patient accommodation: hospitals in all State/Territories

1. Circumstances

Clause 1 provides that Schedule 4 applies, where a policy covers a type of hospital treatment, and the treatment is provided to a nursing-home type patient (NHTP) at a hospital.

2. Interpretation

Clause 2 provides the definition of a NHTP for private health insurance purposes. A patient becomes a NHTP after they have received hospital treatment at a hospital for a continuous period of hospitalisation exceeding 35 days and are then receiving accommodation and nursing care as an end in itself.

3. Application

Clause 3(1) is an application clause which relates to patients who were admitted to hospital, or returned to hospital with less than a seven day break from a previous hospital admission, on or after the commencement of the *Private Health Insurance (Benefit Requirements) Amendment Rules 2007 (No.4)* on 23 November 2007.

4. Provision of acute care

Clause 4 allows a NHTP who requires acute care to cease being a NHTP for the period of acute care and then become a NHTP again once they are again receiving accommodation and nursing care as an end in itself.

5. Ceasing and resuming hospital treatment

Clause 5 provides that a NHTP who leaves hospital but returns to a hospital, whether or not the same hospital, not more than 7 days later will continue to be a NHTP for each subsequent day the patient is provided with accommodation and nursing care as an end in itself until the patient ceases to be provided with hospital treatment at a hospital for a period of more than 7 days.

6. Minimum benefit

Clause 6 provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 1 of Schedule 4 is the amount set out in Table 1 or 2 of Schedule 4 (as applicable).

These Rules increase the minimum benefit payable per night for NHTPs at public hospitals in the Northern Territory from $71.76 to $75.23.

Schedule 5 – Second-tier default benefits

The purpose of second-tier default benefits is to protect quality private facilities and to provide an incentive for private facilities to become accredited and meet other administrative criteria, hence increasing the level of quality hospital care available to consumers.

Schedule 5 sets the minimum benefits for most episodes of hospital treatment (excluding treatment provided to nursing-home type patients) provided at private hospitals specified in Schedule 5 payable by insurers. However, if the hospital has a negotiated agreement with an insurer, the terms of that negotiated agreement may require the hospital to accept an amount of payment that is different to the minimum benefit for a particular episode of hospital treatment.

The Schedule 5 minimum benefit will generally be higher than the basic minimum benefit set by Schedules 1, 2, or 3 of the Rules. However, if in a particular case the level of benefit set by Schedule 5 should be less than the level of benefit set by Schedules 1, 2, or 3 then the level of benefit set by Schedules 1, 2, or 3 (as applicable) applies.

1. Interpretation

Clause 1(1) provides the definition of ***facility*** for the purpose of Schedule 5. A ***facility*** means a private hospital specified in clause 4 of Schedule 5.

Clause 1(2) provides that in Schedule 5 (except for clause 1(4)), the ACT is taken to be part of NSW and the Northern Territory is taken to be part of the State of South Australia.

Clause 1(3) provides that private hospitals are comparable if they fall within the same category from the list contained in this clause.

Clause 1(4) provides for a definition of the term ***licensed beds***.

2. Circumstances

Clause 2 provides that Schedule 5 applies where a policy covers a type of hospital treatment, and the treatment:

- is provided to a patient who is not a nursing-home type patient; and
- the treatment is provided at a facility.

3. Minimum benefit

Clause 3(1) provides that the minimum benefit for hospital treatment provided in the circumstances specified in clause 2 of Schedule 5 is the amount worked out using the method set out in Schedule 5. (Note that if a hospital has a negotiated agreement with an insurer, the terms of that negotiated agreement may require the hospital to accept an amount of payment that is different to the minimum benefit for a particular episode of hospital treatment. The definition of 'negotiated agreement' is included at Part 1, Rule 3).

Clause 3(2) provides that if the minimum benefit worked out in accordance with the method set out in Schedule 5 for an episode of hospital treatment is below the amount set out in

Schedules 1, 2, or 3, the minimum benefit is the amount set out in Schedules 1, 2, or 3 for that episode of hospital treatment.

Clause 3(3) provides that if a hospital ceases to be a facility, the minimum benefit continues to apply as if the hospital continued to be a facility at the time the treatment was provided, in relation to insured persons who were admitted patients at the facility, or booked for hospital treatment at the facility, before the hospital ceased to be a facility.

Clause 3(4) provides that the minimum benefit payable by a private health insurer for an episode of treatment is an amount no less than 85% of the average charge for the equivalent episode of hospital treatment under that insurer's negotiated agreements with all comparable private hospitals in the State in which the facility is located.

Clause 3(4) also provides the timeframes for the calculation of 85% of the average charge for an equivalent episode of hospital treatment.

Clause 3(5) provides for the formula for calculating the ***average charge for the equivalent episode of hospital treatment*** by an insurer in each State.

Clause 3(6) provides that in clause 3(4), each ***episode of hospital treatment*** must be identified using the patient classification system and payment structure in the majority of the relevant insurer's negotiated agreements in force on 1 August of the first year with all comparable private hospitals in the State in which the facility is located.

Clause 3(7) provides that in clause 3(4), for the purpose of calculating the ***average charge for the equivalent episode of hospital treatment*** in a State with all comparable private hospitals

in the State in which the facility is located certain matters are to be included and certain matters are not to be included.

Clause 3(8) provides the method for calculating the minimum benefit for insurers with less than 5 negotiated agreements in force on 1 August of the first year with a particular category of comparable private hospitals in a State. In such cases, all of that insurer's negotiated agreements with all classes of private hospital in that State are to be used to calculate the minimum benefit.

4. Facilities

Clause 4 provides that the hospitals specified in the table at clause 4, Schedule 5 are facilities for the purpose of Schedule 5.

These Rules remove two facilities from the list of Second Tier default benefit facilities following notification of their closure.

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DEPARTMENT OF HEALTH AND AGEING
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