EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health

Private Health Insurance Act 2007
Private Health Insurance (Complying Product) Rules 2015

Section 333-20 of the *Private Health Insurance Act 2007* (the Act) provides that the Minister may make *Private Health Insurance (Complying Product) 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 Chapter 3 of the Act.

The *Private Health Insurance (Complying Product) Rules 2015* (the Rules) commence on 1 July 2015. The Rules revoke the *Private Health Insurance (Complying Product) Rules 2010 (No. 2)* (the Previous Rules).

The Act requires that complying health insurance products must comply with a range of requirements including that:

- products be community-rated, that is, made available in a way that does not discriminate between people;
- products be in the form of a complying health insurance product; and
- private health insurers who make the products available must meet certain obligations to people insured or seeking to be insured under the products.

The Rules include an amended description of permitted content of standard information statements under Schedule 4 of the Previous Rules to account for the abolition of the Private Health Insurance Administration Council (PHIAC) by the *Private Health Insurance (Prudential Supervision) (Consequential Amendments and Transitional Provisions Act 2015* and the replacement of the prudential regulation of the private health insurance industry by the Australian Prudential Regulation Authority (APRA) by the *Private Health Insurance (Prudential Supervision) Act 2015*.

Further the Rules remove a number of redundant notes and provisions from the Previous Rules. These provisions were inserted following the transition of private health insurance regulation from the *National Health Act 1973* to the Act and subsequently are no longer necessary. Additionally a number of provisions from the Previous Rules have had minor amendments to their wording to more accurately reflect the drafting of like provisions in the Act.

Consultation
Treasury, APRA and select industry stakeholders were consulted on the drafting of these rules.

Regulation Impact Statement
The Office of Best Practice Regulation has advised that no Regulatory Impact Statement is required.

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*.

Authority: Section 333-20 of the *Private Health Insurance Act 2007*.

ATTACHMENT

DETAILS OF THE *PRIVATE HEALTH INSURANCE (COMPLYING PRODUCT) RULES 2015*

PART 1 Preliminary

1. Name of Rules

Rule 1 provides that the title of the Rules is the *Private Health Insurance (Complying Product) Rules 2015* (the Rules).

2. Commencement

Rule 2 provides that the Rules are to commence on 1 July 2015.

3. Revocation

Rule 3 provides that the Rules revoke the *Private Health Insurance (Complying Product) Rules 2010 (No. 2)*.

3A. Authority

Rule 3A provides that the Rules are made under the *Private Health Insurance Act 2007*.

4. Definitions

Rule 4 defines certain terms for the purposes of the Rules. A definition has been added for 'general medical services table'. This term has the same meaning as in subsection 3(1) of the *Health Insurance Act 1973*.

PART 2 General

5. Insured Groups

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

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

Paragraph 5(1)(b) sets out the composition of insured groups for policies that are a non-student policy, other than non-student policies referred to in paragraph (c).

Paragraph 5(1)(c) sets out the composition of insured groups for policies that cover 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 ***non-student policy*** as a complying health insurance policy that covers one or more dependent child non-student.

6. Maximum percentage of discount

Subrule 6(1) provides that the maximum percentage discount allowed for the categories of people listed under subparagraph 66-5 (1) (c) (ii) of the Act is 12% per annum.

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

Subrule 6(3) provides that a full premium 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.

Subrule 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.

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

Subrule 6(5) also excludes from the calculation of net premium in subrule 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

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

Subrule 7(2) provides that if a person was entitled to a specified benefit 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.

Subrule 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.

Subrule 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.

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.

Subrule 8(1), made for the purpose of subsection 69-1(2) of the Act, provides in Item 1 of the table to subrule 8(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.

Item 2 of the table to subrule 8(1) provides that if a policy covers hospital treatment, then where hospital treatment includes the provision of a prosthesis listed in the *Private Health Insurance (Prostheses) Rules,* the policy must cover the provision of the prosthesis, provided that:

(a) the treatment includes the provision of a prosthesis of a kind listed in the *Private Health Insurance (Prostheses) Rules;* and
(b) either
    (i) a medicare benefit is payable for the professional service associated with the provision of the prosthesis; or
    (ii) the provision of the prosthesis is associated with podiatric treatment by an accredited podiatrist; or
    (iii) for a prosthesis that is an insulin infusion pump:
        (A) the insulin infusion pump is provided during a professional services for which a medicare benefit is payable; and
        (B) the professional service is a professional attendance by a consultant physician in the practice of his or her specialty; and
        (C) the professional service is provided as a certified Type C procedure or certified overnight Type C procedure; and
        (D) the insulin infusion pump is provided for the purpose of administering insulin.

Item 3 of the table to subrule 8(1) provides that if a policy covers hospital-substitute treatment, then where hospital treatment includes the provision of a prosthesis listed in the *Private Health Insurance (Prostheses) Rules*, the policy must cover the prosthesis, provided that a medicare benefit is payable in respect of the professional service associated with the provision of the prosthesis.

Subrule 8(2) provides, for the avoidance of doubt, that a policy of a kind mentioned in the table to subrule 8(1) may also provide cover for other types of treatment, unless excluded by rules made for the purpose of subsection 69-1(3) of the Act.

8A. Benefit Requirements – 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

nursing-home type patients (NHTP) 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.

Paragraph 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 $56.90, New South Wales is $56.90, Northern Territory is $56.90, Queensland is $56.90, South Australia is $56.90, Tasmania is $56.90, Victoria is $56.90 and Western Australia is $56.90.

Paragraph 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 $56.90.

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.

Subrule 9(1) provides that the waiting period requirements in section 75-1 of the Act are, as permitted by subsection 75-1(2) of the Act, modified by subrule 9(2).

Subrule 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.

Subrule 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, changes in the number of insured persons in particular age groups, 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, changes in the nature of the episodes of hospital treatment and hospital-substitute treatment, for which benefits are paid in particular age group and changes in the average amount of benefits paid for an insured person, or an episode of hospital treatment or hospital-substitute treatment, in 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

Subrule 13(1) provides that Part 3 of the Rules, and Schedules 1, 2, 3, and 4 set out the permitted form and content of a statement about a product subgroup of a complying health

insurance product (complying product).

Subrule 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 subrule 13(2).

Subrule 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 a product subgroup of a complying product made up of 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 a product subgroup of a complying product made up of 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 a product subgroup of a complying product made up of 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.

PART 4 Pilot Projects

17. Kinds of pilot projects

Rule 17 provides the kinds of pilot projects that an insurer can conduct as specified for by subsection 55-15(2) of the Act, with a limited group of policy holders, a program that is being considered for broader implementation.

Insurers are permitted to conduct pilot projects that aim to achieve any or all of the following:

(a) to increase the value to consumers of their health insurance products by better meeting their needs;
(b) to prolong health, improve quality of life and reduce expenditure on hospital benefits by preventing and reducing disease and prevent the need for hospitalisation;
(c) to produce products that better reflect advances in medical knowledge and service delivery models.

18. Requirements of pilot projects

Rule 18 sets the requirements that all pilot projects must meet.

An insurer must not charge a person to participate in the project. Due to the trial nature of pilot projects and the potential cost benefits that an insurer may gain through the pilot process, the cost associated with running the pilot project must be met by the insurer. While it is accepted that benefits may also accrue to participants, there will be no additional charge made against any insured person to participate.

Participation in the pilot project must be on a voluntary basis. While insurers can target individuals to participate in a pilot project, individual policy holders have the right to choose whether or not to participate.

The Rules provide that an insurer may restrict participation in a pilot project on the basis of where a person lives. Limiting participation in a pilot project on the basis of any other reason listed in subsection 55-5(2) would amount to improper discrimination as defined by the Act.

A two year limit on pilot projects is consistent with the trial and development nature of a pilot project. Two years is considered sufficient to trial and evaluate a pilot project without leaving the community rating exception open to abuse. In addition, a written plan, including a timeline and evaluation process prior to commencement is required to ensure compliance with the Act. The written plan must be provided to the Department of Health at least 28 days before the pilot project commences.

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.

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.

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Private Health Insurance (Complying Product) Rules 2015

This Legislative Instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Legislative Instrument

The *Private Health Insurance (Complying Product) Rules 2015* (the Rules) revoke the *Private Health Insurance (Complying Product) Rules 2010 (No. 2)* (the Previous Rules) to include an amended description of permitted content of standard information statements under Schedule 4 of the Previous Rules to account for the abolition of the Private Health Insurance Administration Council by the *Private Health Insurance (Prudential Supervision) (Consequential Amendments and Transitional Provisions Act 2015* and the replacement of the prudential regulation of the private health insurance industry by the Australian Prudential Regulation Authority by the *Private Health Insurance (Prudential Supervision) Act 2015*.

Further, the Rules remove a number redundant notes and provisions from the Previous Rules.

Human rights implications

This legislative instrument engages Articles 2 and 12 of the International Covenant on Economic, Social and Cultural Rights by assisting with the progressive realisation by all appropriate means of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Private health insurance regulation assists with the advancement of these human rights by improving the governing framework for private health insurance in the interests of consumers. Private health insurance regulation aims to encourage insurers and providers of private health goods and services to provide better value for money to consumers, to improve information provided to consumers of private health services to allow consumers to make more informed choices when purchasing services and requires insurers not to differentiate the premiums they charge according to individual health characteristics such as poor health.

Conclusion

This legislative instrument is compatible with human rights because it advances the protection of human rights.

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