

Private Health Insurance (Risk Equalisation Administration) Rules 2015

I, Ian Laughlin, delegate of APRA make these Rules under subsection 333-25, for the purposes of section 318-15, of the *Private Health Insurance Act 2007*.

This instrument takes effect on the day item 166 of Schedule 1 to the *Private Health Insurance (Prudential Supervision) (Consequential Amendments and Transitional Provisions) Act 2015* commences*.*

Dated: 26 June 2015

[Signed]

Ian Laughlin

Deputy Chairman

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## Part 1 – Preliminary

### Name of Rules

These Rules are the *Private Health Insurance (Risk Equalisation Administration) Rules 2015*.

### Commencement

These Rules commence on the day item 166 of Schedule 1 to the *Private Health Insurance (Prudential Supervision) (Consequential Amendments and Transitional Provisions) Act 2015* commences.

### Interpretation

Note: Terms used in these Rules have the same meaning as in the Act – see section 13 of the *Legislative Instruments Act 2003*. These terms include:

APRA

complying health insurance policy

cover

health benefits fund

officer

policy holder

private health insurer

risk equalisation jurisdiction

1. In these Rules:

***Act*** means the *Private Health Insurance Act 2007*.

***adult*** is as defined in the Act.

***Business Rules*** means the *Private Health Insurance (Health Insurance Business) Rules 2013* made under the Act.

***chronic disease*** ***management program*** or ***CDMP***:

* 1. has the same meaning as in the Business Rules; and
	2. for hospital treatment, includes a program similar to a chronic disease management program as referred to in the definition of ‘eligible benefit’ in the Risk Equalisation Policy Rules.

***fund*** means a health benefits fund.

***general treatment*** is as defined in the Act.

***hospital cover*** is as defined in the Act.

***hospital‑substitute treatment*** is as defined in the Act.

***hospital treatment*** is as defined in the Act.

***medicare benefit*** is as defined in the Act.

***insured person***, in relation to a policy,means a person covered by the policy.

***insurer*** means a private health insurer.

***PHIAC*** means the Private Health Insurance Administration Council continued in existence under subsection 264-1(1) of the Act, as it existed immediately prior to the commencement of the *Private Health Insurance (Prudential Supervision) Act 2015*.

***policy*** means a complying health insurance policy.

***quarter*** means a period of 3 months ending on 31 March, 30 June, 30 September or 31 December in a year.

***quarterly return*** means a return required under the *Financial Sector (Collection of Data) Act 2001* relating to risk equalisation information.

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

1. In these Rules, a ***category of policy*** is to be identified as follows:
	1. for a policy under which only one person is insured – as ‘single’;
	2. for a policy under which 2 adults are insured (and no‑one else) – as ‘couple’;
	3. for a policy under which 2 or more people are insured, none of whom is an adult – as ‘2 + persons, no adults’;
	4. a policy under which 2 or more people are insured, only one of whom is an adult – as ‘single parent’;
	5. a policy under which 3 or more people are insured, only 2 of whom are adults – as ‘family’;
	6. a policy under which 3 or more adults are insured – as ‘3 + adults’.
2. In these Rules, the following terms relevant to the high cost claimants pool have the same meaning as in the Risk Equalisation Policy Rules:

***age based pool (ABP)***

***designated threshold***

***high cost claimants pool (HCCP)***

***gross benefit.***

## Part 2 – Requirement for records to be kept

### General records

For each fund conducted by an insurer, the insurer must keep records that contain the following details about each policy of the fund:

* 1. the name, date of birth, age and principal place of residence of each person covered by the policy; and
	2. which of the following the policy covers:
		+ 1. hospital treatment;
			2. hospital-substitute treatment;
			3. chronic disease management programs;
			4. ambulance service;
			5. other general treatment; and
	3. whether the policy includes any excesses or co‑payments payable; and
	4. the category of policy by reference to the number of adults and dependent children covered; and

Note:   Subrule 3 (2) deals with the identification of ‘categories of policies’.

* 1. for each benefit that is paid to or on behalf of an insured person:
		+ 1. the name of the insured person to whom the benefit relates; and
			2. the medical or health speciality for which the benefit was paid; and
			3. whether the benefit was paid for:
				1. hospital treatment; or
				2. hospital-substitute treatment; or
				3. chronic disease management program treatment; or
				4. ambulance services; or
				5. other general treatment; and
			4. if the treatment was provided in accordance with a chronic disease management program, the type of disease for which the program was provided and whether the treatment was provided as hospital treatment or general treatment; and
			5. the gross benefits paid; and
			6. the date of treatment; and
			7. the date of payment.

### High cost claimants pool records

1. This rule applies if the insurer includes in a quarterly return a gross benefit for the high cost claimants pool.
2. In addition to the information to be kept in accordance with rule 4, the insurer must keep a record that contains the following information in respect of the insured person to whom the gross benefit relates:
	1. the name and age of the person; and
	2. the dates of the treatment; and
	3. the gross benefits paid; and
	4. the dates of payment; and
	5. the amount of gross benefit included in the age based pool; and
	6. the amount of gross benefit included in the high cost claimants pool; and
	7. the amount of gross benefits paid for any of the preceding 3 quarters (after 1 April 2007).

## Part 3 – Transition

### Transition

Any approval, determination or other exercise of discretion by PHIAC under Part 1 or Part 2 of the *Private Health Insurance (Risk Equalisation Administration) Rules 2007* as they existed prior to 1 July 2015 will continue to have effect following 1 July 2015 as though exercised pursuant to a corresponding power under these Rules.