EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health

Private Health Insurance Act 2007

Private Health Insurance (Reforms) Amendment Rules 2018

Authority

Section 333-20 of the *Private Health Insurance Act 2007* (the Act) authorises the Minister for Health, by legislative instrument, to make *Private Health Insurance Rules* providing for matters required or permitted by the corresponding Chapter, Part or section to be provided; or necessary or convenient to be provided in order to carry out or give effect to that Chapter, Part or section. The Private Health Insurance (Reforms) Amendment Rules 2018 (the Amendment Rules) makes amendments to the Private Health Insurance Rules as referred to in the table presented below:

Private Health Insurance Rules	**Chapter/Part/section**
Private Health Insurance (Incentives) Rules	Part 2-2, section 206-1, Part 6-4
Private Health Insurance (Lifetime Health Cover) Rules	Part 2-3
Private Health Insurance (Complying Product) Rules	Chapter 3 and section 188-1
Private Health Insurance (Benefit Requirements) Rules	Part 3-3
Private Health Insurance (Health Insurance Business) Rules	Part 4-2
Private Health Insurance (Prostheses) Rules	Part 3-3

The Amendment Rules are a legislative instrument for the purposes of the *Legislation Act 2003*.

Background

On 13 October 2017, the Government announced a package of reforms designed to make private health insurance simpler and more affordable for all Australians. The *Private Health Insurance Legislation Amendment Act 2018* amended the *Private Health Insurance Act 2007* and associated legislation to enable a number of reforms, as well as establishing a framework to support the implementation of some reforms through subordinate legislation.

The Amendment Rules include amendments associated with the commencement of the following reforms (and related matters):

- age-based premium discounts for hospital cover
- improving information provisions for consumers
- introduction of product tiers and clinical categories for hospital cover
- the administration of second-tier default benefits arrangements for hospitals

- removal of coverage for some natural therapies
- technical changes to references to podiatric surgeons.

The age-based premium discount provisions will allow private health insurers to offer this discount on hospital policies to individuals aged 18 to 29 years of age when they first purchase insurance, making private health insurance more affordable. As long as an insurer continues to offer the discounts, people with age-based discounts will retain them until the age of 41, from which age the discount will phase out at the rate of two percentage points a year.

The amendments to the information provision requirements will make it easier for consumers to compare health insurance policies on offer in the market, while allowing private health insurers to personalise aspects of any additional information they provide to individual customers.

The amendments introduce new rules to categorise hospital products as either gold, silver, bronze or basic, depending on the services they cover, and to require insurers to use a defined set of clinical categories to describe the coverage they provide.

These reforms will provide consumers with greater certainty about the treatments covered by each type of product. They will also make it easier for consumers to understand the information they receive about insurance policies and to compare competing policies.

The administrative arrangements for a hospital's eligibility to receive second-tier default benefits will be changed under the amendments set out in these Rules, with the administration of eligibility applications to be undertaken by the Department of Health.

Some natural therapies are now excluded from private health insurance for general treatment as part of the reforms to make private health insurance more affordable. Insurers may continue to offer access to these excluded therapies as inducements for people to purchase health insurance, as long as the cost of all incentives is not more than 12 per cent of the premium.

Commencement

The Amendment Rules commence on the day after this instrument is registered and on later dates, as set out in the following table.

Provisions	**Amendment Topic**	**Commencement**
Sections 1 to 4	Technical	The day after this instrument is registered.
Schedule 1	Age-based discounts	1 April 2019
Part 1 of Schedule 2	Standard Information Statement	1 January 2019
Part 2 of Schedule 2	Private Health Information Statement	1 April 2019
Part 3 of Schedule 2	Repeal transitional Information Statement provisions	1 April 2020

Provisions	Amendment Topic	Commencement
Part 1 of Schedule 3	Product tiers and clinical categories	1 April 2019
Part 2 of Schedule 3	Repeal transitional product tier and clinical category provisions	1 April 2020
Schedule 4	Second tier administrative reforms	1 January 2019
Schedule 5	Removal of coverage of some natural therapies	1 April 2019
Schedule 6	Information provision	1 April 2019
Schedule 7	Accredited podiatrist technical amendment	The day after this instrument is registered.

Transitional provisions apply to some changes. They are outlined in the details of the Amendment Rules.

Details

Details of the Amendment Rules are set out in **Attachment A**.

Consultation

From 16 July 2018, a three week period was provided for public comment on an exposure draft of the Amendment Rules. A large number of interested groups were invited to comment, including health insurance funds and their peak associations, and a number of peak bodies for clinicians and other health professionals, consumers and hospitals.

The Department of Health received significant feedback from the private health insurance and hospital sectors, as well as from a range of health professional organisations, individual health practitioners, consumer organisations, and individuals. In additions, the Department continued to consult with industry peak bodies and various clinical groups when incorporating the feedback into the Amendment Rules.

Statement of Compatibility with human rights

Subsection 9(1) of the *Human Rights (Parliamentary Scrutiny) Act 2011* requires the rule-maker in relation to a legislative instrument to which section 42 (disallowance) of the *Legislation Act 2003* applies to cause a statement of compatibility to be prepared in respect of that legislative instrument. The Statement of Compatibility has been prepared to meet that requirement and is included at **Attachment B.**

ATTACHMENT A

DETAILS OF THE *PRIVATE HEALTH INSURANCE (REFORMS) AMENDMENT RULES 2018*

Section 1 Name

Section 1 provides that this instrument is the *Private Health Insurance (Reforms) Amendment Rules 2018* (the Amendment Rules).

Section 2 Commencement

Section 2 sets out when the Amendment Rules and various schedules within it commence.

Section 3 Authority

Section 3 provides that the Authority for this instrument is section 333-20 of the *Private Health Insurance Act 2007* (the Act).

Section 4 Schedules

Section 4 provides that an instrument that is specified in a Schedule to the instrument (the Amendment Rules) is amended or repealed as set out in the applicable items in the schedule concerned. There are seven schedules contained within the Amendment Rules.

Schedule 1 – Amendments – Age-based discounts

Private Health Insurance (Complying Product) Rules 2015

Following amendments to paragraph 55-5(2)(c) and the insertion of new paragraph 66-5(3)(ea) into the Act to provide for age-based discounts for hospital cover, the amendments in this schedule set out the requirements for an age-based discount policy to be a complying health insurance policy in line with new paragraph 66-5(3)(ea). In addition, the Schedule also provides a table that specifies the discount percentage a person may be eligible to receive according to the age they become insured, and an additional table that sets out how the discount percentage will be reduced once the person reaches the age of 41.

Age-based discounts can be offered separately or in addition to any other discounts referred to in subsection 66-5(3) of the Act.

Age-based discounts may be offered for hospital cover to people aged 18 to 29 when they first purchase an age-based discount policy. Insurers may offer premium discounts on hospital cover of two percentage points for each year that a person is aged under 30, with a maximum of 10 percentage points for 18 to 25 year olds. Where an age-based discount is offered it must be made available on the same basis to all policy holders on a product.

Once a person is receiving an age-based discount, the person will be entitled to continue to receive that discount until the person turns 41 (unless the insurer chooses to discontinue age-based discounts under the product, or the person transfers to a different insurance policy, that does not provide for the discount to be retained). When a person turns 41, any age-based discount that a person holds will decay at the rate of 2 percentage points per year, so that no age-based discounts are available after the age of 45.

Item 1 Rule 4 (note at the end of the rule)
This item amends the note at the end of Rule 4, to include the terms “adult” and “hospital cover”. These terms have the same meaning as in the Act.

Item 2 Subrule 6(3)
Subrule 6(3) currently provides that the full premium for the purpose of calculating maximum allowable discounts is the premium that would be received by the private health insurer for a policy in the same product subgroup covering the same combination of people without any reduction due to the circumstances set out in paragraphs 66-5(3)(a) to (e) of the Act, which specify permitted reasons for discounting.

This item amends subrule 6(3) to reflect the introduction of age-based discounts referred to in paragraph 66-5(3)(ea) of the Act.

Items 3 and 4 Subrule 6(5)
Subrule 6(5) provides a list of costs that are excluded from the calculation of net premiums under subrule 6(4) for the purpose of calculating the maximum allowable

discount. They currently include brokerage fees, commissions, particular discounts and promotions offered on joining.

Items 3 and 4 amend subrule 6(5) to provide that any age-based discount that might apply in relation to the policy is also to be disregarded for the purposes of subrule 6(4.) This means that any premium reductions provided as age-based discounts are excluded from the maximum percentage discount of 12 per cent per annum set out under subrule 6(1). A person aged 18 to 25 purchasing hospital insurance for the first time could thus receive a discount of 10 per cent as an age-based discount and 12 per cent for other reasons such as advance payment set out in section 66-5(3) of the Act.

Item 5 After Part 2

This item inserts a new Part 2A after Part 2 to establish the requirements for:

- an age-based discount policy to be a complying health insurance policy for the purposes of paragraph 63-10(g) of the Act and
- the calculation of age-based discounts for the purpose of paragraph 66-5(3)(ea) of the Act.

Insurers are not required to offer age-based discount policies under any product as a result of Part 2A. They are simply enabled to offer age-based discounts on products if they wish. Similarly, if individual insurers choose to offer age-based discount policies, Part 2A does not oblige them to make age-based discounts available for all ages between 18 and 29 (inclusive). Nor does it oblige them to continue to offer age-based discounts under a product.

Rule 11A provides definitions for new terms used in this Part including, “age-based discount policy”, “discount assessment date”, “eligible person” and “retained age-based discount policy”.

An “aged-based discount policy” is defined as an insurance policy that provides age-based discounts.

The definition of “discount assessment date” sets out the circumstances which determine this date for an insured person. This date is critical for establishing the discount that applies to a person, and can be established in three ways:

(a) the date the person became insured under a policy that provided age-based discounts or
(b) the date the person was first eligible for an age-based discount – if the policy the person purchased provides age-based discounts at a date after the person becomes insured or
(c) if a person transfers from a policy (the “old policy”) to a new policy which is stated to be a retained age-based discount policy, the person’s discount assessment date under the old policy. (“Transfers” has the same meaning as in section 75-10 of the Act.)

An “eligible person” in this Part means, in relation to an age-based discount policy, a person to whom a discount applies in accordance with paragraph 11B(c).

A “retained age-based discount” means an insurance policy that is an age-based discount policy and states that it is a retained age-based discount policy. This allows insurers to decide whether to provide the same discount to persons transferring to an age-based discount policy as they had under their previous policy. However, the decision cannot be made on an individual basis, and must be applied in the same way to all people transferring to the product.

Rule 11B sets out the requirements that apply to a complying health insurance policy that provides an age-based discount. For the purposes of paragraph 63-10(g) of the Act, an insurance policy must not provide an age-based discount unless the policy covers hospital treatment or hospital treatment and general treatment and the discount (equal to a dollar amount) is calculated in accordance with rule 11C.

In addition, the discount offered under the policy is to apply to each person insured under the policy who, on their respective “discount assessment date” was within one or more ages, between 18 and 29 (inclusive) years of age, that are specified under the policy as eligible for a discount and who are not a dependent child under the policy.

This allows insurers to specify the ranges of ages, between 18 and 29 (inclusive), for which discounts will be available under an age-based discount policy. However, if an insurer makes age-based discounts available in relation to particular ages or particular ranges of ages for a particular product, the age-based discounts must be available in relation to those ages or ranges on the same terms and conditions for all insurance policies under that product (see section 63-5 of the Act).

A further requirement of an age-based discount policy is that while age-based discounts remain available under a policy the discount will continue to apply to each eligible person insured under the policy until it is reduced to zero, in accordance with Rule 11C.

An age-based discount policy must also state whether it is a retained age-based discount policy, in which case people transferring to the policy from another age-based discount policy will retain their discount assessment date that applied under the old policy, and consequently the “applicable percentage” (calculated in accordance with Rule 11C) applying at the time of transfer. (If a person transfers to a third or subsequent policy they retain their discount assessment date and applicable percentage, as long as each successive policy is stated to be a retained age-based discount policy.)

Rule 11C provides the method for calculating the age-based discount for an eligible person, and how the discount will be reduced once the eligible person reaches the age of 41.

This rule deals only with the calculation of the age-based discount. The premium that is payable in respect of a particular insurance policy is also affected by other provisions of the Act (including Part 2-3 of the Act, which deals with lifetime health cover (LHC)) and rules made under the Act (including these Rules).

Insurers will need to take account of all relevant provisions when calculating the premium payable for an individual policy which includes an age-based discount.

For age-based discount policies where one insured person is eligible for an age-based discount and the other has a LHC loading, each component will be applied to the relevant person's proportion of the policy's base rate for hospital cover. This is the same principle as when a policy covers two people but only one has an LHC loading, or they have different LHC loadings.

For the discount eligible person, the applicable discount will be calculated in accordance with Clause 11C of the *Private Health Insurance (Complying Product) Rules 2015* (the Complying Product Rules). For the person who has a LHC loading the amount of the increase would be worked out in accordance with the LHC provisions in Part 2-3 of the Act (section 37-20 provides for joint hospital cover).

The combined effect of both calculations will provide the total increase, or decrease, to apply to the policy's premium.

An age-based discount policy can cover more than one person. Rule 11C stipulates that the total age-based discount that applies under an age-based discount policy for a particular period is equal to the sum of the applicable discounts which apply to each eligible person insured under that policy who is entitled to an age-based discount for that period.

Rule 11C also sets out the formula to calculate an eligible person's applicable discount.

An eligible person's applicable discount is the result of:

- the "base rate for hospital cover" multiplied by the "applicable percentage" then
- divided by the "number of adults insured".

These terms are defined for the purposes of Rule 11C as:

- "applicable percentage" for a particular period is the greater of:
  - a person's percentage for the period, determined in accordance with the table set out in subrule 11C. This table sets out the different rates of discount that apply to the different age groups from 18 years to 45 years or older by reference to a person's "base percentage".
  - the "base percentage" is set out in subrule 11C(4). The person's age at their discount assessment date will determine the base percentage applicable to them. If a person is 18 or older, but under 26, the base percentage is 10 per cent. From the age of 26 the rate reduces by two percentage points for each successive age until 29, when the base percentage is two per cent.
- "base rate for hospital cover", which is calculated by reference to the amount of premiums that would have been payable if:
  - the premiums were not increased under Part 2-3 of the Act (LHC) and
  - there were no discounts of the kind allowed under subsection 66-5(2) of the Act (including under the Complying Product Rules as amended by these Rules)
- "number of adults insured" is the number of adults insured under the policy.

If a person is receiving an age-based discount, the person is entitled to continue to receive the full discount until the person turns 41 (unless the insurer chooses to discontinue age-based discounts under the product, or the person transfers to a different insurance policy). The discount is then reduced by two percentage points by each year that a person ages.

Rule 11D sets out the circumstances in which a person is entitled to an age-based discount for a particular period.

For the purposes of paragraph 66-5(3)(ea) of the Act, which enables age-based discounts to be one of the discounts allowed to be offered under the Act, a person is entitled to an age-based discount for a period if the person meets three criteria:

- they are insured under an age-based discount policy during that period and
- they are an eligible person, as defined in Rule 11A, in relation to that policy and
- their applicable discount for that period, which is calculated in accordance with subrule 11C(2), is not equal to zero.

Schedule 2 – Amendments – Standard information statements and private health information statements

Private Health Insurance (Complying Product) Rules 2015

The Government announced on 13 October 2017 that the requirements placed on insurers to provide information on their policies to consumers and to the Private Health Insurance Ombudsman would be amended. Rather than supplying consumers with a Standard Information Statement in a fixed and inflexible format, insurers would be able to provide consumers with the information contained in a private health information statement, but would also be able to personalise this information to make it more relevant to the requirements of individual consumers.

Following amendments to Divisions 93 and 96 of the Act made by the *Private Health Insurance Legislation Amendment Act 2018*, this schedule amends the Complying Product Rules to introduce the requirements for the new private health information statement ("the information statement").

Nothing in the amended Rules will prevent insurers from providing more information than the minimum requirements to consumers seeking information about policies, or to insured persons about their policies, if insurers choose to do so.

The information statement requirements will reflect the introduction of the gold/silver/bronze/basic product tiers for hospital policies, established through the amendments to the Rules set out in Schedule 3 of these amending Rules. As insurers are not required to apply the product tiers until 1 April 2020, insurers are not obliged to meet the related information statement requirements until that date. The following table sets out how the transition requirements in this schedule operate.

Main requirement		Transition rules
1 January 2019		
Standard Information Statements (SIS)	Item 3, new Rule 12 – must meet the requirements of new Schedules 1, 2, and 3	Item 4, new Rule 20 – a SIS that met the requirements of the Rules before they were amended on 1 January 2019 is taken to comply with new Schedules 1, 2, and 3
1 April 2019		
Private Health Information Statements	Introduced by Item 15, amendments to new Schedules 1, 2 and 3	Item 8, amends Rule 20 to provide that the transition period does not apply to a gold, silver, bronze or basic policy
1 April 2020		
Private Health Information Statements		Item 16 – repeals Rule 20 so all information statements must comply with new Schedules 1, 2, and 3

This transitional timing is consistent with Rule 21 (inserted by Item 3 in Schedule 3 of these amending Rules) setting out the transitional arrangements for the system of gold/silver/bronze/basic hospital product tiers.

Part 1 – Amendments commencing on 1 January 2019

Item 1 Rule 4
This item amends Rule 4 to insert a new definition of "State" which will apply to the use of this term in the new Schedules 1, 2 and 3 inserted by Item 5.

For the purposes of these new schedules, "State" means a risk equalisation jurisdiction as set out in the *Private Health Insurance (Health Benefits Fund Policy) Rules 2015*. This means that for the purposes of these schedules in the Complying Product Rules (as amended by these Rules):

- the Australian Capital Territory, Norfolk Island and New South Wales form a risk equalisation jurisdiction
- Western Australia, the Territory of Christmas Island and the Territory of Cocos (Keeling) Islands form a risk equalisation jurisdiction
- all other states or territories form separate, individual risk jurisdiction areas whose name corresponds to the name of the state or territory (e.g. Northern Territory, Queensland).

Item 2 Rule 4 (note at the end of the rule)
This item inserts the term "risk equalisation jurisdiction" into the note at the end of Rule 4. The purpose of this note is to make it clear that unless the contrary intention appears, the terms set out in the list, which are used in the Rules, have the same meaning as the Act.

Item 3 Part 3
This item repeals Part 3, which provides the current requirements for standard information statements and replaces them with the new requirements for standard information statements and other information that must be given in the new Part 3.

As this part commences on 1 January 2019, private health insurers may provide standard information statements that meet these new requirements to those they insure from that date. However, under new Rule 20 inserted by Item 4 insurers may continue to supply standard information statements that meet the requirements of Part 3 of the Rules before they were repealed by this Item 3 until:

- 1 April 2020; or
- the information statement relates to a policy that is a "gold", "silver", "bronze" or "basic" policy (see Item 8 below).

The note set out at the beginning of new Part 3 makes it clear that this part is concerned with:

- the information to be included in standard information statements, and the form in which that information is to be presented (for the purposes of subsection 93-5(1) of the Act)
- the methods by which standard information statements are made available and
- information relating to changes in premiums that must be provided to the Private Health Insurance Ombudsman.

The note also makes it clear that new Part 3 does not limit the information an insurer may give to an insured person. Effectively, Part 3 sets out the minimum information requirements to be provided to an insured person or the Private Health Insurance

Ombudsman in a standard information statement. It is open to insurers to provide additional information about their policies if they choose.

This item inserts a new Rule 12 under new Part 3. For the purposes of subsection 93-5(1) of the Act, this new rule identifies which of the new schedules in Part 3 insurers need to use so that a product subgroup of a complying health insurance product contains the necessary information and is in the correct form of words.

- All standard information statements need to include the information set out in Schedule 1 (for example, the name of the policy, the name of the private health insurer, the state in which the product is available, the monthly premium and who is covered by the policy).
- If the policy covers hospital treatment then additional information set out in Schedule 2 needs to be included (for example, information on what is included or not included in a policy).
- If the policy covers general treatment then the additional information set out in Schedule 3 needs to be included (for example information relating to policies which are only available with a hospital policy).
    - If the only general treatment offered in an individual policy is ambulance cover, then the requirements of Schedule 3 do not apply.
    - This information will already be included in the standard information statement as any information about ambulance cover is part of the information required by Schedule 1.

Rule 13 sets out the method of making standard information statements available. This rule is made for the purposes of subsection 93-5(2) and paragraph 93-15(1)(a) of the Act.

This rule provides that if insurers provide additional information in the same document to accompany the information and form of words required under Rule 12 (which references new Schedules 1, 2 and 3 inserted by Item 5), the additional information must not obscure or contradict the information which is required to be provided. As long as the required information is provided clearly and in the correct form of words, insurers may add any additional information they wish.

Rule 14 is made for the purposes of section 96-25 of the Act, and applies to private health insurers if the Minister for Health has approved a proposed change to the premiums they can charge for a complying health insurance product. The Rule requires private health insurers to notify the Private Health Insurance Ombudsman of the premiums that applied before and after the approval, by the earlier of the day 14 days after the date of the Minister's approval for the change or 1 April of the year in which the Minister approved the change.

The information provided by insurers will enable the Private Health Insurance Ombudsman to have up-to-date information on its website allowing consumers to compare products more easily and make better informed purchasing decisions.

Item 4 After rule 19

This item inserts a new Rule 20, applying until 31 March 2020, which provides for transitional arrangements to apply to standard information statements.

This rule allows a standard information statement that contains the information, and is in the form, that was required under the Rules that were in force immediately before the commencement of these amending Rules on 1 January 2019 to be taken as a standard information statement for the purposes of the amended Rules. A standard information statement in this form is called the "old form".

Effectively, this means that insurers may offer the standard information statement in either the "old form" or in a way that meets the new requirements after 1 January 2019. This continues to apply even after private health information statements requirements take effect on 1 April 2019, under the amendment made to Rule 20 by Item 9 in Part 2 of this schedule. The transitional arrangement, allowing use of the "old form", applies only until:

- 1 April 2020; or
- the information statement relates to a policy that is a "gold", "silver", "bronze" or "basic" policy (see Item 8 below).

Item 5 Schedules 1, 2, 3 and 4

This item repeals current Schedules 1, 2, 3 and 4 of the Complying Product Rules, which provide the current requirements relating to the form and content of standard information statements. The new Schedules 1, 2 and 3 replace the repealed schedules. These new schedules set out the minimum information requirements that private health insurers must give to insured persons and the Private Health Insurance Ombudsman from 1 January 2019.

Schedule 1 identifies the information and form of words that apply to all policies. Clause 1 provides that a reference to a policy is a reference to a policy that forms part of the relevant product subgroup. Product subgroup has the same meaning as the Act. This interpretive clause is also included at the beginning of both new Schedule 2 and new Schedule 3.

The table in Clause 2 of Schedule 1 contains 13 items which must be covered. These items include information such as the policy name, the name of the private health insurer, the monthly premium and who is covered under the policy.

Schedule 1 requires information about ambulance cover to be provided. The information that must be provided includes:

- whether ambulance cover is included in the policy
- whether there is a waiting period, any limits on cover or call-out fees
- whether free ambulance services are provided by the relevant State (and if so, the extent of these services)
- whether ambulance cover provides benefits for cover provided by another person (for example, ambulance subscription service payments).

While this schedule sets out what information insurers need to provide, it does not specify the language for providing this information, except where text in an individual table item is set out in quotation marks. For example:

- in table item 3 – Disclaimer for restricted access insurers – this statement must be included "Membership of this insurer is restricted to" to be followed by the relevant details

- table item 6 – Monthly premium – the words "before any rebate, loading or discount" must be inserted before or following the premium amount
- table item 9 – Who is covered – "only one person" and "two adults (and no-one else)" are examples of the terms insurers must use to describe insured groups that may be covered under a policy.

Schedule 2 identifies the additional information and form of words for the standard information statement that apply to policies that include hospital treatment. The table in Clause 2 of Schedule 2 contains 10 items which must be covered. These items include information such as:

- information relating to policies that are available only with a general treatment policy
- what is included in the policy and what is not
- restrictions – if there are any that apply
- waiting periods that apply to a policy before benefits are payable
- extra costs per day (co-payments).

Schedule 2 also allows insurers to include a statement that indicates any other features of the policy to which the insurer wishes to draw attention. This could include, for example, benefits for travel or accommodation or the availability of age-based discounts. Insurers must limit this statement to 100 words at most, which will be included on the Private Health Insurance Ombudsman's website. Although there is a limit to the words required as part of the formal information statement, to ensure usability for comparison, this does not limit insurers' ability to provide other information in the same document.

This schedule, like Schedule1, sets out what information insurers need to provide. It does not specify the language for providing this information, except where text in an individual table item is set out in quotation marks. For example, in table item 2 – Whether policy exempts holders from the Medicare Levy Surcharge – insurers must use either of the following statements, whichever is applicable:

- "This policy exempts you from the Medicare Levy Surcharge" or
- "This policy does not exempt you from the Medicare Levy Surcharge".

Schedule 3 identifies the additional information and form of words for the standard information statement that apply to policies that include general treatment. The table in Clause 2 of Schedule 3 contains 9 items which must be covered. These items include information such as:

- information relating to policies that are available only with a hospital treatment policy
- preferred service provider arrangements
- treatments that are covered or not covered by the policy
- benefit limits.

This schedule also requires insurers to include a statement that indicates any other features of the policy to which the insurers wishes to draw attention. Again the word limit is 100 words.

As with Schedules 1 and 2, Schedule 3 specifies what information is required, but not how it needs to be said by insurers, except where particular text is included in quotation marks in an individual table item.

Part 2 Amendments commencing on 1 April 2019

Private Health Insurance (Complying Product) Rules 2015

The amendments to the Complying Product Rules which commence on 1 April 2019 reflect the amendments made to Division 93 – Giving information to consumers – of the Act which also commence on 1 April 2019. These amendments to the Act provide for standard information statements to be known as "private health information statements" from 1 April 2019.

Item 6 After rule 14

This item inserts a new Rule 15, made for the purposes of section 96-25 of the Act. It specifies certain types of information that private health insurers are required to include when providing a private health information statement to newly insured and existing policy holders (consistent with the requirement of section 93-15 or subsection 93-20(1) of the Act). The insurer must provide:

- the name of each person covered by the policy and
- if the product subgroup to which the policy belongs covers hospital treatment, details of the LHC loading applicable to any of the individuals covered by the policy and the period remaining before the loading is removed.

Rule 15 also provides that the insurer does not need to inform the insured person of this information more than once in any 12 month period.

This rule also allows private health insurers to provide additional information to accompany the mandatory information in this rule, subject to the same limits imposed by Rule 13 on information statements. The additional information must not obscure or contradict the information which is required to be provided. As long as the required information is provided clearly and in the correct form of words, insurers may add any additional information they wish.

Item 7 After rule 15

This item inserts a new Rule 16, made for the purposes of section 93-5(2) of the Act, which deals with how information is to be provided to persons asking about insurance products. Insurers must provide a private health information statement by post, or, if the person has asked for it to be provided in another manner, in that other manner as long as it is reasonably practicable. This will allow insurers to provide information by methods such as email or text, or via a webpage, as long as the person seeking the information has agreed to receive information by that particular method.

Item 8 Before subrule 20(1)

This item inserts a new subrule 20(1A) to provide that the transitional provisions set out in Rule 20 do not apply to insurance policies which provide hospital treatment and have any of the words "gold", "silver", "bronze" or "basic" in the name of the policies.

Schedule 3 of these amending Rules provide for the establishment of a system of gold/silver/bronze/basic product categorisation of hospital policies. Any policy that meets these new requirements must include the relevant product tier in the name of the policy. Subrule 20(1A) thus provides that the information statement for a policy that meets the product categorisation requirements must comply with the information requirements set out in the new Schedules 1, 2 and 3 inserted by this amending schedule.

Item 9 Subrule 20(3)
This item repeals subrule 20(3) inserted by Item 4, which provided that a standard information statement which met the requirements of the Rules that were in force immediately before the commencement of these amending Rules on 1 January 2019 was to be taken as a standard information statement for the purposes of the amended Rules.

It replaces it with a provision that a private health information statement which meets the requirements of the Rules that were in force immediately before the commencement of these amending Rules on 1 January 2019 is to be taken as a private health information statement for the purposes of the amended Rules. This will allow insurers that choose not to introduce policies meeting the new product tier requirements added by Schedule 3 of these amending Rules to continue to use information statements that met the standard information statement requirements applying before 1 January 2019. (Insurers have until 1 April 2020 to comply with the product tier requirements – see Rule 21.)

The transitional arrangement, allowing use of the "old form", applies only until:

- 1 April 2020; or
- the information statement relates to a policy that is a "gold", "silver", "bronze" or "basic" policy (see Item 8 above).

Item 10 Clause 2 of Schedule 1 (table item 1)
This item repeals table item 1 in Clause 2 of Schedule 1 entitled "Policy name" and substitutes a new table item that provides for the policy name to take account of Rules 11H and 11J which govern the naming of policies that cover hospital treatment (i.e. "gold", "silver", "bronze", "basic") and policies that cover general treatment.

A new note also draws attention to the application of transitional provisions to this table item, which are set out in Rule 21. The note indicates that Rule 21 (inserted by Item 3 in Schedule 3 of these amending Rules) setting out the transitional arrangements for the system of gold/silver/bronze/basic hospital product categorisation is also relevant to this item.

Item 11 Clause 2 of Schedule 2 (table item 3)
This item repeals table item 3 in Clause 2 of Schedule 2 and substitutes a new table item which provides for insurers to indicate what treatments are included, or not included, in a policy by way of referencing the relevant clinical category to which that treatment belongs. Clinical categories are set out in Schedule 3 of these amending Rules. Insurers will also be required to indicate if accident cover or benefits for travel and accommodation will be included in the policy.

A new note also draws attention to the application of transitional provisions to this table item, which are set out in Rule 21.

Item 12 Clause 2 of Schedule 2 (table item 4)
This item repeals table item 4 in Clause 2 of Schedule 2 and substitutes a new table item. This table item provides for insurers to list all clinical categories (if any) that have restrictions on them.

A new note also draws attention to the application of transitional provisions to this table item, which are set out in Rule 21.

Item 13 Clause 2 of Schedule 2 (table item 5, column headed "Additional information and form of words", paragraph (b))
This item omits the word "treatment" from table item 5 and substitutes it with the words "clinical categories". This amendment reflects the changes to nomenclature and categorisation of treatments from 1 April 2019 under Schedule 3 to these amending Rules.

Item 14 Clause 2 of Schedule 2 (table item 5, column headed "Additional information and form of words", after note 2)
This item inserts a third note into the list of notes for this table item. The new note draws attention to the application of transitional provisions to this table item, which are set out in Rule 21. The note indicates that Rule 21 (inserted by Item 3 in Schedule 3 of these amending Rules) setting out the transitional arrangements for the system of gold/silver/bronze/basic hospital product categorisation is also relevant to this item.

This is a note to new table item 5 in new Schedule 2, which is amended by both this Item and Item 13 mentioned above.

Item 15 Amendments of listed provisions – private health information statements
This item provides for the amendment of 18 provisions within the Complying Product Rules, to replace the term "standard information statement" with the term "private health information statement" to reflect the application of the latter term from 1 April 2019.

Part 3 Amendments commencing on 1 April 2020

Private Health Insurance (Complying Product) Rules 2015

Item 16 Rule 20
This item repeals Rule 20 as the transitional arrangements for which it provides are no longer applicable from 1 April 2020.

Item 17 Clause 2 of Schedule 1 (table item 1)
This item repeals table item 1 and substitutes a new table item "Policy name", which requires insurers to provide the name of the policy, noting that Rules 11H and 11 J apply to the naming of policies.

Item 18 Clause 2 of Schedule 2 (table item 3, column headed "Additional information and form of words", note)
This item repeals the note from this table item that referred to transitional provisions that are defunct as of 1 April 2020.

Item 19 Clause 2 of Schedule 2 (table item 4, column headed "Additional information and form of words", note)
This item repeals the note from this table item that referred to transitional provisions that are defunct as of 1 April 2020.

Item 20 Clause 2 of Schedule 2 (table item 5, column headed "Additional information and form of words", note 3)
This item repeals the note from this table item that referred to transitional provisions that are defunct as of 1 April 2020.

Schedule 3 – Amendments – Product tiers and related amendments

Part 1 Amendments commencing on 1 April 2019

Private Health Insurance (Complying Product) Rules 2015

Schedule 3 establishes new rules to categorise hospital products as either gold, silver, bronze, or basic, depending on the services they cover, and to require insurers to use a defined set of clinical categories to describe the coverage they provide.

These reforms will provide consumers with greater certainty about the treatments covered by each type of product. They will also make it easier for consumers to understand the information they receive about insurance policies and to compare competing policies.

Insurers have until 1 April 2020 to comply with these requirements for a policy providing that, from 1 April 2019 onward, the policy does not use in its name:

- "gold", "silver", "bronze" or "basic"
- the name of any other metal or
- the name of any gemstone or semi-precious stone.

This means that a policy that uses the word "gold", "silver", "bronze" or "basic" in its name must comply with the new requirements, and a policy that includes the name of any other metal or the name of any gemstone or semi-precious stone may not be provided from 1 April 2019 onward.

Rule 21, inserted by Item 3 in this schedule, provides for this transition period.

Item 1 Rule 4
Rule 4 inserts definitions for specific terms that support the new product design for private health insurance.

A "clinical category" means a category set out in the new Schedule 5 inserted by Item 4 in this amending schedule.

A "gold policy" is one that covers hospital treatment and covers the treatments in all of the clinical categories required for a gold policy in the new Schedule 4 inserted by Item 4 in this amending schedule. The structure of Schedule 4 requires a gold policy to cover all clinical categories.

A "silver policy" is one that covers hospital treatment, covers the treatments in all of the clinical categories required for a silver policy in the new Schedule 4, but is not a gold policy.

A "bronze policy" is one that covers hospital treatment, covers the treatments in all of the clinical categories required for a bronze policy in the new Schedule 4, but is not a silver or gold policy.

A “basic policy” is one that covers hospital treatment, covers the treatments in all of the clinical categories required for a basic policy in the new Schedule 4, but is not a bronze, silver or gold policy

A “product tier” for a policy, means either gold, silver, bronze or basic according to whether the policy is a gold, silver, bronze or basic policy.

Item 1A Rule 4 (note at the end of the rule)
This item adds the term “medical practitioner” to the list of terms set out in Rule 4 which have the same meaning as they do in the Act.

Item 2 After Part 2A

This item inserts a new Part 2B after Part 2A which specifies the requirements for products tiers and names of insurance policies.

The notes inserted directly under the heading for Part 2B clarify that:

- Part 2B specifies additional requirements that an insurance policy must meet in order to be a complying health insurance policy for the purposes of paragraph 63-10(g) of the Act.
- Nothing in Part 2B affects the operation of Division 72 of the Act (which refers to benefit requirements for policies that cover hospital treatment) or the operation of the Private Health Insurance (Benefit Requirements) Rules for the calculation of minimum benefits where restricted cover is allowed under Rule 11G. The Amendment Rules do not mean that payments above minimum benefits are required for all treatments in all circumstances. This is discussed further in the explanation of new Rule 11G below.

Rule 11E requires that a policy covering hospital treatment must be either a gold, silver, bronze or basic policy. This rule is subject to the transition set out in Rule 21.

Rule 11F sets out the requirements for coverage of treatment for policies covering hospital treatment for a policy to be a complying health insurance policy under section 63-10 of the Act. Again, this rule is subject to the transition set out in Rule 21

Paragraph 11F(2)(a) provides that if a policy covers a clinical category it must cover all hospital treatment within the scope of cover identified in Schedule 5. This provision has an inclusive scope, and the scope of cover is not limited by the fact that an MBS item is not included in a relevant Schedule.

Subrule 11F(5) provides that the scope of cover for a clinical category includes, but is not limited to,

- in paragraph 5(a) – all hospital treatment involving the provision of an MBS item listed against the clinical category in Schedule 5, and
- in paragraph 5(b) – all hospital treatment that falls within the scope of cover referred to in paragraph 2(a) or the MBS items referred to in paragraph 5(a), and that involve the provision of an MBS item listed in the Common treatments list in Schedule 6 (inserted by Item 4) or the Support treatments list in Schedule 7 (also inserted by Item 4).

Subrule 11F(6) provides that paragraph (5)(b) does not apply to the podiatric surgery clinical category. Insurers are only required to pay, as they do now if they cover podiatric surgery, accommodation benefits and prostheses for treatments within this clinical category.

Paragraph 11F(2)(b) also requires the policy to cover treatments that are not within the scope of cover of a clinical category covered under the policy, but that are associated treatment for complications (see subrule (7)) or associated unplanned treatments (see subrule (8)).

Subrule (7) provides that associated treatment for complications is treatment provided during an episode of hospital treatment, where that episode is within the scope of cover of the patient's policy, to address a complication arising during that episode. For example, if a person has surgery for a digestive illness and they develop acute arrhythmia during the episode of hospital treatment, attendance by a cardiologist and cardioversion would be covered even if the person's policy did not otherwise cover the heart and vascular system clinical category.

Subrule (8) provides that associated unplanned treatment is treatment provided during planned surgery that is not within the scope of cover of the patient's policy, but that is, in the view of the medical practitioner providing the unplanned treatment, medically necessary and urgent.

Subrule (3) provides that a policy that covers hospital treatment is not required to cover cosmetic surgery that is not medically necessary.

Subrule (4) provides that a policy may also provide accident cover or benefits for travel and accommodation. This provision ensures that it is clear that these types of cover can be included in the description of what is covered by a policy in information statements even though they are not clinical categories.

Rule 11G outlines whether a policy may provide restricted cover. Restricted cover is a term used in the insurance sector generally to describe cover under which the insurer undertakes to pay only the minimum default benefit set out in Schedules 1, 2, 3 and 4 of the Private Health Insurance (Benefit Requirement) Rules.

Different provisions apply for gold, silver, bronze and basic policies. This rule is subject to the transition set out in Rule 21.

Restricted cover is not permitted for gold policies. A gold policy must provide unrestricted cover for all clinical categories.

Silver and bronze policies may provide either restricted or unrestricted cover for the clinical categories of rehabilitation, hospital psychiatric services and palliative care. Silver and bronze policies must provide unrestricted cover for all other clinical categories that a silver or bronze policy is required to cover and any other additional clinical categories that the policy covers.

A basic policy may provide either restricted or unrestricted cover for any of the clinical categories that the policy covers. The only mandatory clinical categories for basic policies are rehabilitation, hospital psychiatric services and palliative care.

For basic policies, Rule 11G does not prevent the policy from providing restricted cover for a selection of hospital treatments within a clinical category and unrestricted cover for other hospital treatments within the same clinical category. However, if a basic policy provides both restricted and unrestricted cover within a single clinical category, the product's private health information statement must indicate that the relevant clinical category is covered on a restricted basis.

For silver and bronze policies it is not possible to provide restricted cover for clinical categories other than rehabilitation, hospital psychiatric services and palliative care. Rule 11G does not prevent a silver or bronze policy from providing restricted and unrestricted cover within any of these three clinical categories. However, if a silver or bronze policy provides both restricted and unrestricted cover within any of these three clinical categories, the product's private health information statement must indicate that the relevant clinical category is covered on a restricted basis.

If a policy provides restricted cover for a particular category, even if a contract is in place between the insurer and a hospital, the insurer is only required to pay basic default benefits for that hospital treatment. A requirement in the Amendment Rules to provide unrestricted cover does not require payment above minimum benefits for all treatments in all circumstances. Where a policy provides unrestricted cover and there is no contract in place between the insurer and a hospital, the insurer is only required to pay either the second-tier default benefit for eligible hospitals, or the minimum default benefit in other cases.

Rule 11H sets outs the naming requirements for insurance policies covering hospital treatment. This rule is subject to the transition set out in Rule 21.

The policy name must include the policy's product tier. If a policy provides cover for clinical categories in addition to the mandatory clinical categories required for its product tier, the policy name may include the word "plus" or the symbol "+". This rule will only apply to basic, bronze and silver policies as gold polices must cover all clinical categories. The fact that a policy provides accident cover or travel and accommodation benefits does not allow it to include a "plus" or "+".

The policy name is not allowed to include the name of any other metal or gemstone.

Rule 11J applies to policies which only offer general treatment. These policies are not allowed to include the names of any metals or gemstones in the name of the policy. This provision applies from 1 April 2019, with no transition period.

Item 3 After rule 20

This item inserts Rule 21 which sets out the transitional provisions which will apply to new Part 2B of the Rules inserted by Item 2 until 31 March 2020.

This rule will apply to policies which cover hospital treatment (whether or not they also provide cover for general treatment). It applies until 31 March 2020.

Part 2B requires policies to meet the requirements of a gold, silver, bronze or basic policy (Rule 11E), and include the name of the relevant product tier in the name of the policy (Rule 11H).

Subrule 21(3) provides that policies that do not have gold, silver, bronze or basic in their name, nor the name of any other metal, gemstone or semi-precious stone, do not need to comply with the requirements of Part 2B (until 31 March 2020). A policy with a name including these terms must comply with Part 2B from 1 April 2019. However, as a policy with the name of any other metal, gemstone or semi-precious stone cannot comply with Part 2B, this means that these policies cannot be offered from 1 April 2019 onwards.

Subrule 21(4) provides that, during the transition period, policies that do not comply with Part 2B may continue to use items in the Schedules setting out the private health information statements as they applied before 1 April 2019.

Item 4 After Schedule 3
This item inserts four new schedules that set out the elements that identify the range of treatments a person's insurance policy should cover for hospital treatment and for which they can expect benefits to be paid.

Schedule 4 – Product tiers and treatments
The table in this schedule sets out the clinical categories which must be included in each of the four product category tiers. A key is provided to help insurers and consumers recognise which clinical categories form the minimum set of clinical categories which must be covered under each product tier. The table also provides a key to show which clinical categories must be covered on an unrestricted basis and which ones may be offered on a restricted basis.

Schedule 5 - Clinical categories.
This schedule is set out as a table which:

- identifies a clinical category (material in Column 1)
- describes the scope of cover for each clinical category (material in Column 2)
- identifies the MBS items that are relevant to hospital treatments within the scope of cover and for which benefits must be paid (material in Column 3).

For example, "Digestive system" is a clinical category identified in Column 1. Its scope of cover is "hospital treatment for the investigation of the digestive system including the oesophagus, stomach, gall bladder, pancreas, spleen, liver and bowel", which is set out in Column 2. Over 300 MBS items are listed in Column 3.

As set out in Rule 11F, the scope of cover of a clinical category is defined by the description in Column 2. The scope of cover includes but is not limited to the list of MBS items in Column 3.

Some hospital treatments could be applicable to the scope of cover of more than one clinical category. In such circumstances, the interpretation provision for this Schedule ensures that treatments are not covered in a clinical category where the scope of cover states that the treatments are listed separately under another clinical category.

The presence of an item number in a category or schedule has no bearing on whether that service requires a hospital admission and should not be interpreted as implying that these services necessarily require admission.

Schedule 6 – Common treatments list
A number of MBS items can be applied to treatments which are commonly used across many of the clinical categories listed in Schedule 5. To assist insurers, these MBS items have been identified and listed in this schedule.

Schedule 7 – Support treatments list
A number of MBS items can be applied to procedures which are commonly used to support the provision of a primary treatment, which may be identifiable under one of the clinical categories listed in Schedule 5 or a treatment with an MBS item listed in Schedule 6. To assist insurers, these MBS items for support treatments have been identified and listed in this schedule.

Part 2 Amendments commencing on 1 April 2020

Private Health Insurance (Complying Product) Rules 2015

Items 5 to 9 repeal the notes in Rules 11E, 11F, 11G and 11H referring to the transitional provisions set out in rule 21, and also repeal Rule 21. This is because the transitional period ends on 31 March 2020.

Schedule 4 – Amendments – Second tier administrative reforms

Under current arrangements hospitals' eligibility to receive second-tier default benefits is assessed by the Second Tier Advisory Committee established under the auspices of the Australian Private Hospitals Association, and made up of representatives from hospital and insurer organisations. Each insurer is responsible for allocating eligible private hospitals to one of seven categories established under the Rules for the purpose of determining comparability in calculating the second-tier default benefit payable by that insurer.

On 13 October 2017 the Government announced that from 1 January 2019 private hospitals would be able to apply directly to the Department of Health (the Department) for recognition that they are eligible for second-tier default benefits, and that the length of a private hospital's second-tier eligibility approval would be increased to align with the hospital's independent hospital accreditation cycle. The Department would be responsible for hospital categorisation.

Part 3 of Schedule 5 of the *Private Health Insurance Legislation Amendment Act 2018* inserted new sections 121-8 to 121-8D into the Act to establish a framework for the new arrangements.

From 1 January 2019, the Department will accept and assess applications for second tier default benefits eligibility on an ad-hoc basis. The Department will align second tier default benefits expiry dates with each hospital's accreditation expiry date when awarding eligibility. Therefore, the length of eligibility will be up to three years, depending on the time during a hospital's accreditation cycle that second tier default benefits eligibility is awarded.

The amendments in this schedule set out assessment criteria for inclusion of a private hospital as a second tier eligible hospital, arrangements for categorisation of private hospitals, matters of a transitional nature relating to current second tier arrangements and the new application process, and impose an application fee for the new application process.

Private Health Insurance (Benefit Requirements) Rules 2011

Item 1 Clause 1 of Schedule 5
Item 1 substitutes a new Clause 1 in Schedule 5. Subclause 1(1) provide definitions for specific terms used in the Rules, including "authorised officer", "comparable", "Hospital Casemix Protocol Data", and "second-tier eligible hospital".

Subclause 1(2) provides that for the purposes of this schedule, the Australian Capital Territory is taken to be part of New South Wales and the Northern Territory is taken to be part of South Australia, except in subclauses 1A(8) and (9).

Item 2 After Clause 1 of Schedule 5
This item inserts clause 1A after Clause 1 to establish the arrangements in respect of the categorisation of hospitals that are to be applied in the calculation of second-tier default benefits.

Subclause 1A(1) provides for the categorisation of hospitals upon the commencement of this schedule on 1 January 2019.

It provides that if, as at 1 January 2019, an authorised officer has published on the Department's website a list of all private hospitals declared under subsection 121-5(6) of the Act which places each hospital in a category as set out in subclause 1A(7), then each hospital is taken to be in that category for the payment of second-tier default benefits.

Subclause 1A(2) provides that, if the list referred to in subclause 1A(1) has not been published by 1 January 2019, an authorised officer must determine the categorisation of hospitals and publish the list on the website as soon as practicable.

The note after subrule 1A(2) explains that while under the transitional provision inserted by Item 7 of this schedule insurers must use the hospital categorisation established by subclauses 1A(1) or (2) to determine the category of a hospital for the payment of second-tier default benefit, they may continue to use the average charge they worked out before the commencement of this schedule in determining the amount payable in each category during the transitional period from 1 January to 31 August 2019.

Subclause 1A(3) requires any private hospital declared under subsection 121-5(6) of the Act from 1 January 2019 onwards to be placed in a category as set out in subclause (7).

Subclause 1A(4) enables the Department to vary existing determinations concerning the categorisation of each private hospital. This variation may be made before 1 June of a particular year.

Subclause 1A(5) requires the Department to publish on its website, a list of private hospitals and their categorisation as of 1 August of each year.

Subclause 1A(6) provides that private hospitals are taken to be 'comparable' with each other if they are placed in the same category by a determination made by the Department under subclauses 1A(1) to (4).

Subclause 1A(7) establishes the categories of second-tier eligible hospitals. A hospital that has been included in the second-tier eligible hospital class under Part 2A of the *Private Health Insurance (Health Insurance Business) Rules 2018* is placed into a category from this subclause as determined by the Department.

These categories are based closely on those in current subclause 1(3). Categories (a) and (b) have been amended to exclude from the psychiatric and rehabilitation categories hospitals that fall within category (g).

Category (g) has been amended to refer to hospitals that provide episodes "only for periods of not more than 24 hours". The previous wording "hospital treatment which does include any part of an overnight stay" was ambiguous. The new wording will ensure that all facilities that can only provide treatment for periods of 24 hours or less are treated the same.

Subclause 1A(8) applies in circumstance where the number of beds or patients permitted in a private hospital is regulated in a given State or Territory. In these circumstances the references to licensed beds in subclause 1A(7) is to be taken as the number of beds or patients permitted at the private hospital in that State or Territory.

Subclause 1A(9) provides that where the number of beds or patients permitted in a private hospital is not regulated in a State or Territory, the references to licensed beds in subclause 1A(7) is to be taken as a reference to the beds and bed equivalents the private hospital operates at the relevant point in time.

Subclause 1A(10) provides that in assessing private hospitals against the criteria for the categories set out in paragraphs 1A(7)(a) and (b) an authorised officer of the Department must use the most recent year of Hospital Casemix Protocol Data if this data is available for the hospital. Otherwise, the officer is to use any relevant information available to the Department.

Subclause 1B provides that a hospital which has received a determination made under subclause 1A (1), (2), (3) or (4) may request an internal review of this decision in writing within 28 days after the day on which the determination is notified to the hospital. The decision must be reviewed by an officer who did not make the original determination, who must then either confirm the decision or make a fresh one within 28 days after the day on which the application was received by the Department.

Item 3 Clause 2 of Schedule 5
This is a technical amendment consequential upon the addition of the defined term "second-tier eligible hospital" to Clause 1.

Item 4 Subclause 3(3) of Schedule 5
This is a technical amendment consequential upon the addition of the defined term "second-tier eligible hospital" to Clause 1. Subclause 3(3) currently provides that if a hospital loses second-tier eligibility, second-tier default benefits continue to be payable for patients who were admitted patients at the time, or who were booked for treatment. The substituted clause maintains this protection.

Item 5 Subclause 3(4) of Schedule 5
The current subclause 3(4) provides for insurers to calculate the second-tier default benefit payable to an eligible hospital for the twelve months starting on 1 September in a given year as 85 per cent of the average charge for an equivalent episode of hospital treatment under that insurer's negotiated agreements that are in force on 1 August that year with comparable private hospitals in the same state. It is up to the insurer to determine which hospitals are comparable.

This item substitutes a new subclause 3(4) to require benefits to be calculated on the same basis and within the same timeframes, except that the comparability of hospitals

is to be determined in accordance with the hospital categorisation established under clause 1A.

Item 6 Subclause 3(6) of Schedule 5
This is a technical amendment consequential upon the addition of the defined term "second-tier eligible hospital" to Clause 1.

Item 7 Clause 4 of Schedule 5
Clause 4 of Schedule 5 of the current *Private Health Insurance (Benefit Requirements) Rules 2011*provides for the current second-tier administrative arrangements.

This item repeals Clause 4 and substitutes it with a new Clause 4 providing for transitional arrangements for calculating the minimum benefit for hospital treatment undertaken or from 1 January until 31 August 2019.

During this period an insurer may work out the average charge for a patient admitted to a second-tier hospital on the basis of the provisions of Schedule 5 as they existed before the commencement of this amending schedule.

This means that while insurers must use the hospital categorisation established by subclauses 1A(1) or (2) to determine the category of a hospital for the payment of second-tier default benefit, they may continue to use the average charge they worked out before the commencement of this schedule in determining the amount payable in each category.

Private Health Insurance (Health Insurance Business) Rules 2018

Item 8 Rule 3
Rule 3 provides definitions for specific terms used in the *Private Health Insurance (Health Insurance Business Rules) 2018*. This item inserts additional terms and definitions in Rule 3 that will be applied under the provisions setting out the new second-tier administrative arrangements.

Item 9 After Part 2
This item inserts a new Part 2A after Part 2 titled "Second-tier eligible hospitals class". The new rules 7A to 7E augment the amendments made to the Act by the *Private Health Insurance Legislation Amendment Act 2018*, which established a legislative framework for the Minister for Health to assess and determine whether or not to include a private hospital in the class of hospitals eligible for second-tier default benefits. One of those amendments provided that a decision by the Minister that a hospital does not meet the criteria set out in new Rule 7C, and a decision by the Minister to revoke the approval of a hospital, are reviewable by the Administrative Appeals Tribunal.

Rule 7A sets out a class of hospital for the purposes of section 121-8(1) of the Act. This clause establishes a class named "second-tier eligible hospitals". A hospital declared to be a private hospital for the purposes of section 121-5(6) of the Act may apply to the Minister to be included in the second-tier eligible hospitals class.

Rule 7B sets out the application fee required for each hospital that the application seeks to have included in the second-tier eligible hospitals class. The application fee will be $850 per hospital in 2018-19.

The Department is fully cost recovering assessment of applications for second-tier default benefits eligibility and publishing of assessment outcomes. The Department has costed this activity at $850 per application, which will be the fee for 2018-19 applications. This fee will be reviewed annually and amended in line with changes in the associated cost to the Department. The Department will publish and maintain a Cost Recovery Implementation Statement on its website to explain how cost recovery has been implemented for this activity.

Rule 7C sets out the assessment criteria to be used by the Minister or his or her delegate to assess an application seeking to have a hospital included in the second-tier eligible hospitals class. The assessment criteria are broadly unchanged from the criteria that were applied by the former Second Tier Advisory Committee.

Rule 7D requires hospitals that have been included in the second-tier eligible hospitals class to notify the Department of material changes in circumstances that may prevent that hospital from continuing to satisfy the eligibility criteria. Examples of matters that may require a notification include changes that affect a hospital's ability to maintain accreditation.

Rule 7E provides transitional arrangements for hospitals that had been eligible for second-tier default benefits by satisfying the criteria in Clause 4 of Schedule 5 to the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Benefit Requirement Rules) repealed by item 7 in this amending Schedule.

The hospitals that are specified in the Second Tier Advisory Committee approved list on 1 January 2019 continue to be eligible to claim the second-tier default benefits specified in Schedule 5 of the Benefit Requirement Rules, until the later of:

- the date on which the hospital's second-tier default benefits eligibility was due to expire or
- the date on which the hospital's accreditation expires, if that date is less than 12 months after the date on which the hospital's second-tier default benefits eligibility was due to expire.

Schedule 5 – Amendments – Removal of coverage of some natural therapies

Private Health Insurance (Health Insurance Business) Rules 2018

The amendment in this schedule defines "excluded natural therapy treatment", and provides that neither hospital treatment nor general treatment can include benefits for excluded natural therapy treatment. It also precludes excluded natural therapy treatment from being included in a health management program if benefits are to be paid by a private health insurer.

From 1 April 2019, benefits for the following natural therapies will no longer be able to be offered by private health insurers as part of a general treatment policy: Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, Western herbalism, homoeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi, and yoga.

Item 1 Rule 3
Rule 3 provides definitions for specific terms used in the *Private Health Insurance (Health Insurance Business) Rules 2018*.

This item amends Rule 3 by inserting the term "excluded natural therapy treatment" which means any of the following treatments: Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, Western herbalism, homeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi, and yoga.

Item 2 Rule 8
Rule 8 specifies the classes of treatments that are excluded from 'hospital treatment' for the purposes of subsection 121-5 (4) of the Act.

This item amends Rule 8 by inserting new paragraph 8(e) to add "excluded natural therapy treatment".

Item 3 Rule 11
Rule 11 specifies the treatments which are excluded from "general treatment" for the purposes of paragraph 121-10(3)(b) of the Act.

This item substitutes a new Rule 11(1) which:

- adds "excluded natural therapy treatment" as a treatment which is specified for the purposes of paragraph 121-10(3)(b) of the Act; and
- amends the meaning of "health management program" to make it clear that "excluded natural therapies" cannot be offered as treatments in such a program.

The effect of this amendment is that insurers are precluded from providing cover or paying benefits for excluded natural therapy treatments under general treatment products, including health management programs.

Schedule 6 – Amendments – Information Provision

This schedule makes a number of amendments to information provision requirements in the Private Health Insurance (Incentives) Rules 2012 (No. 2) and the Private Health Insurance (Lifetime Health Cover) Rules 2017.

Private Health Insurance (Incentives) Rules 2012 (No. 2)

Item 1 Rule 4 (note)
This item omits the words "standard information statement" and substitutes the words "private health information statement".

Item 2 Rule 4 (definition of Australian Government Rebate on private health insurance)
This item repeals the definition of "Australian Government Rebate on private health insurance" and substitutes an updated definition omitting any reference to the private health insurance incentive payments scheme as this no longer operates.

Item 3 Rule 7
This item repeals Rule 7, which was only relevant to the private health insurance incentive payments scheme which no longer operates.

Item 4 Paragraph 8(1)(a)
Rule 8 currently specifies the conditions of participation in the premiums reduction scheme, and currently requires insurers to issue annual statements setting out the amount of premium paid for a policy during a year and the amount paid under the premium reduction scheme.

This item substitutes a new paragraph 8(1)(a) under which the insurer must only issue the statement on request.

Item 5 Subparagraph 8(1)(c)(ii)
This item amends subparagraph 8(1)(c)(ii) to omit the word "annual" to ensure consistency with paragraph 8(1)(a) as amended in item 4.

Item 6 Rule 9
Rule 9 currently sets out a series of limitations on the material that may be included with or accompany a statement under paragraph 8(1)(a). This item substitutes a less prescriptive Rule, which requires insurers to set out the required information clearly and distinctly, and provide it within 14 days of receipt of the request, by post or in the manner requested by the person seeking it if it is reasonably practicable to do so. This will allow insurers to provide information by methods such as email or text, or via a webpage, as long as the person seeking the information has agreed to receive information by that particular method.

Private Health Insurance (Lifetime Health Cover) Rules 2017

Item 7 Subrule 8(1)
This Rule currently requires insurers to provide a policy holder information about the impact on the premium of LHC loadings at any time on request. This information

must also be provided annually, together with information about the insurer's record of the policy holder's days without hospital cover.

This substitutes a new subrule 8(1), which removes the requirement for an insurer to provide this information annually, and replace it with a requirement to provide the information on request.

However, Item 17 in Schedule 2 to these amending Rules inserts a new Rule 15 into the Complying Product Rules which requires insurers, when giving a person a private health information statement in accordance with section 93-15 or subsection 93-20(1) of the Act, to provide:

- the name of each person covered by the policy and
- if the product subgroup to which the policy belongs covers hospital treatment, details of the LHC loading applicable to any of the individuals covered by the policy and the period remaining before the loading is removed.

Rule 15 also provides that the insurer does not need to inform the insured person about the information about LHC loadings more than once in any 12 month period.

Item 8 Subrule 8(3)
This item substitutes a new subrule 8(3) requiring insurers to provide information that has been requested by a policy holder under amended subrule 8(1) to be provided either by post, or in another manner requested by the policy holder (provided it is reasonably practicable), within 14 days of the request. This will allow insurers to provide information by methods such as email or text, or via a webpage, as long as the person seeking the information has agreed to receive information by that particular method.

Schedule 7 – Amendments relating to accredited podiatrists

Private Health Insurance (Complying Product) Rules 2015

Item 1 Rule 4 (definition of accredited podiatrist) and item 2 Rule 4
Item 1 amends Rule 4 to repeal the current definition of accredited podiatrist (and the associated note about this definition), and Item 2 inserts a new definition into the Rule.

The new definition of "registered podiatric surgeon" as "a podiatric surgeon who holds specialist registration in the specialty of podiatric surgery under the National Law" will be consistent with the definition for this type of health professional under the *Private Health Insurance (Accreditation) Rules 2011*. The new definition reflects contemporary usage and nomenclature for this type of health professional who provides selected surgical procedures for the foot and ankle.

The note to this new definition makes it clear that the registration requirements for a registered podiatric surgeon for the purposes of these Rules are the same as those for the Private Health Insurance (Accreditation) Rules as made from time to time.

Item 3 Subrule 8(1) (table item 2, column headed "Kind of policy" subparagraph (b)(ii))
This item makes a consequential amendment to subrule 8(1).

Private Health Insurance (Prostheses) Rules 2018 (No.2)

Item 4 Rule 4 (definition of accredited podiatrist) and item 5 Rule 4
Item 5 amends Rule 5 to repeal the current definition of accredited podiatrist (and the associated note about this definition) and Item 2 inserts a new definition into the Rule.

The new definition of "registered podiatric surgeon" as "a podiatric surgeon who holds specialist registration in the specialty of podiatric surgery under the National Law" will be consistent with the definition for this type of health professional under the *Private Health Insurance (Accreditation) Rules 2011*and the Complying Product Rules (as amended by Item 2 above).

The note to this new definition makes it clear that the registration requirements for a registered podiatric surgeon for the purposes of these Rules are the same as those for the Private Health Insurance (Accreditation) Rules as made from time to time.

Item 6 Paragraph 7(a)
This item makes a consequential amendment to paragraph 7(a).

ATTACHMENT B

Statement of Compatibility with Human Rights

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

Private Health Insurance (Reforms) Amendment Rules 2018

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 (Reforms) Amendment Rules 2018* amend the *Private Health Insurance (Complying Product) Rules 2015* to set out the requirements for insurers to be able to offer age-base premium discounts and the requirements they must meet in providing information on their private health insurance policies. These Rules also introduce new nomenclature and standardised clinical categories for policies offering hospital cover. Consumers and insured persons will have greater certainty about the treatments covered by each type of policy. The amendments also make it easier for consumers to understand the information they receive about insurance policies, to compare competing policies and select policies best suited for their needs.

These Rules also amend the *Private Health Insurance (Health Benefit Requirements) Rules 2011* and the *Private Health Insurance (Health Insurance Business) Rules 2018* to change the administrative arrangements for private hospitals seeking recognition for second tier default benefits. Private hospitals will have a reduced administrative burden as a result.

The *Private Health Insurance (Health Insurance Business) Rules 2018* are also amended to exclude certain natural therapies from insurance policies for hospital and general treatment. The objective of these reforms is to reduce the costs of private health insurance for consumers.

These Rules also make consequential amendments to the *Private Health Insurance (Incentives) Rules 2012 (No.2)*, the *Private Health Insurance (Lifetime Health Cover) Rules 2017* and the *Private Health Insurance (Prostheses) Rules 2018 (No.2)* to support the new requirements for information provision and changes to defined terms.

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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