

**A Bill for an Act to amend laws relating to private
health insurance, and for related purposes**

The Parliament of Australia enacts:

1 Short title

This Act is the *Private Health Insurance Legislation Amendment
Act 2018*.

2 Commencement

- (1) Each provision of this Act specified in column 1 of the table commences, or is taken to have commenced, in accordance with column 2 of the table. Any other statement in column 2 has effect according to its terms.

No. , 2018

Private Health Insurance Legislation Amendment Bill 2018

1

Commencement information		
Column 1	Column 2	Column 3
Provisions	Commencement	Date/Details
1. Sections 1 to 3 and anything in this Act not elsewhere covered by this table	The day this Act receives the Royal Assent.	
2. Schedules 1 and 2	1 April 2019.	1 April 2019
3. Schedule 3	1 July 2018.	1 July 2018
4. Schedule 4, Parts 1 and 2	1 April 2019.	1 April 2019
5. Schedule 4, Part 3	1 January 2019.	1 January 2019
1	Note:	This table relates only to the provisions of this Act as originally enacted. It will not be amended to deal with any later amendments of this Act.
2		
3		
4	(2)	Any information in column 3 of the table is not part of this Act.
5		Information may be inserted in this column, or information in it
6		may be edited, in any published version of this Act.
7	3 Schedules	
8		Legislation that is specified in a Schedule to this Act is amended or
9		repealed as set out in the applicable items in the Schedule
10		concerned, and any other item in a Schedule to this Act has effect
11		according to its terms.

Schedule 1—Increasing maximum excess levels

A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999

1 Subsection 4(1)

Omit “(1)”.

2 Paragraph 4(1)(b)

Repeal the paragraph, substitute:

- (b) any excess payable in respect of benefits under the policy is no more than the applicable amount set out in section 87-1 of that Act in any 12 month period.

3 Subsections 4(2), (4) and (5)

Repeal the subsections.

Medicare Levy Act 1986

4 Paragraph 3(5)(b)

Repeal the paragraph, substitute:

- (b) any excess payable in respect of benefits under the policy is no more than the applicable amount set out in section 87-1 of that Act in any 12 month period.

5 Subsections 3(5A), (6) and (7)

Repeal the subsections.

Private Health Insurance Act 2007

6 After Part 3-3

Insert:

Schedule 1 Increasing maximum excess levels

Part 3-3A—Excess levels for complying health insurance products

Division 85—Introduction

85-1 What this Part is about

This Part sets out the excess levels for complying health insurance products that relate to whether a person is liable to pay medicare levy or medicare levy surcharge.

Division 87—Excess levels for complying health insurance products

87-1 Excess level amounts

For the purposes of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999* and the *Medicare Levy Act 1986*, any excess payable in respect of benefits under a *complying health insurance policy that provides *hospital cover must not be more than:

- (a) \$750 in any 12 month period, in relation to a policy under which only one person is insured; and
- (b) \$1,500 in any 12 month period, in relation to any other policy.

7 Application

The amendments made by items 2, 4 and 6 of this Schedule apply in relation to the 2018-19 and later income years.

EXPOSURE DRAFT

Discounted hospital cover products for 18 to 29 year olds **Schedule 2**
Main amendments **Part 1**

FOI 26-3059
Document 49

Schedule 2—Discounted hospital cover products for 18 to 29 year olds

Part 1—Main amendments

Private Health Insurance Act 2007

1 Paragraph 55-5(2)(c)

Repeal the paragraph, substitute:

(c) the age of a person, except to the extent allowed under:

(i) Part 2-3 (lifetime health cover); or

(ii) subsection 63-5(4); or

(iii) section 66-5, because of the reason mentioned in
paragraph 66-5(3)(ea); or

2 After paragraph 66-5(3)(e)

Insert:

(ea) because a person insured under the policy is entitled to an
age-based discount in the circumstances set out in the Private
Health Insurance (Complying Product) Rules;

EXPOSURE DRAFT

FOI 26-3059
Document 49

Schedule 2 Discounted hospital cover products for 18 to 29 year olds
Part 2 Consequential amendments

1 **Part 2—Consequential amendments**

2 *Age Discrimination Act 2004*

3 **3 Schedule 2 (table item 9A, column headed “Provision(s)”)**

4 Omit “Part 2-3 and subsection 63-5(4)”, substitute “Part 2-3,
5 subsection 63-5(4) and paragraph 66-5(2)(a), because of the reason
6 mentioned in paragraph 66-5(3)(ea)”.

7 **4 Schedule 2 (after table item 9A)**

8 Insert:

9

10	<i>Private Health Insurance (Complying Product) Rules</i> made under the <i>Private Health Insurance Act 2007</i>	rules made for the purposes of the reason mentioned in paragraph 66-5(3)(ea) of the <i>Private Health</i> <i>Insurance Act 2007</i>
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10

6 *Private Health Insurance Legislation Amendment Bill 2018* No. , 2018

Schedule 3—Private Health Insurance Ombudsman's powers

Ombudsman Act 1976

1 After Division 3 of Part IID

Insert:

Division 3A—Inspection and audit

Subdivision A—Inspection and audit

20SA Powers to conduct inspections and audits

- (1) The Private Health Insurance Ombudsman may, at any reasonable time of the day:
 - (a) enter a place mentioned in subsection (2); and
 - (b) exercise the powers mentioned in subsection (3) in relation to the place.
- (2) For the purposes of paragraph (1)(a), the Private Health Insurance Ombudsman may enter:
 - (a) a place occupied by a private health insurer or private health insurance broker; or
 - (b) a place occupied by a person predominantly for the purpose of performing services for, or on behalf of, a private health insurer or private health insurance broker; or
 - (c) a place where documents or other records relating to a private health insurer, a private health insurance broker or the carrying on of health insurance business are kept.
- (3) For the purposes of paragraph (1)(b), the Private Health Insurance Ombudsman may exercise the following powers in relation to a place mentioned in subsection (2):
 - (a) the power to inspect any documents or other records to:
 - (i) verify evidence provided in relation to a complaint made under Division 3; or

Schedule 3 Private Health Insurance Ombudsman's powers

- 1 (ii) ensure that a private health insurer or private health
2 insurance broker has complied, or is complying with,
3 their responsibilities in relation to complying health
4 insurance policies or complying health insurance
5 products;
6 (b) the power to take extracts from, or make copies of, any such
7 document or other record.
- 8 (4) A person commits an offence if:
9 (a) the person is the occupier of, or is in charge of, a place
10 mentioned in subsection (2); and
11 (b) the Private Health Insurance Ombudsman exercises, or
12 purports to exercise, the powers mentioned in subsection (3)
13 in relation to the place; and
14 (c) the person does not provide the Private Health Insurance
15 Ombudsman with reasonable facilities and assistance for the
16 effective exercise of the Private Health Insurance
17 Ombudsman's powers.
- 18 Penalty for contravention of this subsection: 30 penalty units.

Subdivision B—Recommendations and reports

20SB Recommendation and reporting powers as a result of inspection or audit

- 22 *Recommendations to insurers or brokers*
- 23 (1) After exercising powers under section 20SA, the Private Health
24 Insurance Ombudsman may:
25 (a) recommend to a private health insurer or private health
26 insurance broker that the insurer or broker take a specific
27 course of action to ensure compliance with their
28 responsibilities in relation to complying health insurance
29 policies or complying health insurance products; or
30 (b) recommend to a private health insurer or private health
31 insurance broker that the insurer or broker make changes to
32 their practices or procedures so as to ensure compliance with
33 their responsibilities in relation to complying health
34 insurance policies or complying health insurance products.

- (2) The Private Health Insurance Ombudsman may, by written notice given to the person to whom the recommendation was made, or an officer of that person, require the person to report to the Private Health Insurance Ombudsman, before action is taken to give effect to the recommendation, on the action proposed to be taken. The notice must specify the period within which the report is to be given.

Reports to the Health Minister

- (3) After exercising powers under section 20SA, the Private Health Insurance Ombudsman may:
- (a) report to the Health Minister on any recommendations made to a private health insurer or private health insurance broker and any responses to those recommendations; or
 - (b) report to the Health Minister on any recommendations to general changes in regulatory practice or industry practices relating to the kind of issues raised as a result of the exercise of those powers.

2 At the end of subsection 20ZG(6)

Add:

- ; (f) a summary of the exercise of powers during the period by the Private Health Insurance Ombudsman under section 20SA;
- (g) an assessment of the extent to which private health insurers and private health insurance brokers generally are complying with their responsibilities in relation to complying health insurance policies or complying health insurance products.

3 Subsection 34(2C)

Omit “and 20V”, substitute “, subsection 20SB(3) and section 20V”.

4 Application

The amendments made by this Schedule apply in relation to a complaint made under Division 3 of Part IID of the *Ombudsman Act 1976* on or after 1 July 2018.

Schedule 4 Miscellaneous

Part 1 Benefits for travel and accommodation

Schedule 4—Miscellaneous

Part 1—Benefits for travel and accommodation

Private Health Insurance Act 2007

1 After subsection 121-5(2)

Insert:

(2A) Without limiting subsection (1) or (2), *hospital treatment* also includes benefits for travel or accommodation relating to treatment covered by subsection (1) or (2).

2 Subsection 121-5(4)

Omit “and (2)”, substitute “, (2) and (2A)”.

3 After subsection 121-10(2)

Insert:

(2A) Without limiting subsection (1) or (2), *general treatment* also includes benefits for travel or accommodation relating to treatment covered by subsection (1) or (2).

4 Subsection 121-10(3)

Omit “and (2)”, substitute “, (2) and (2A)”.

1 **Part 2—Information requirements**

2 *Private Health Insurance Act 2007*

3 **5 Section 93-1 (heading)**

4 Omit “standard information statements”, substitute “private health
5 information statements”.

6 **6 Subsection 93-1(1)**

7 Omit “*standard information statement”, substitute “*private health
8 information statement”.

9 **7 Subsection 93-1(1A)**

10 Omit “*standard information statement may be the standard information
11 statement”, substitute “*private health information statement may be the
12 private health information statement”.

13 **8 Subsections 93-1(2) and (3)**

14 Omit “*standard information statement”, substitute “*private health
15 information statement”.

16 **9 Paragraph 93-1(4)(a)**

17 Omit “*standard information statement”, substitute “*private health
18 information statement”.

19 **10 Paragraph 93-1(4)(b)**

20 Omit “standard information statement”, substitute “private health
21 information statement”.

22 **11 Section 93-5 (heading)**

23 Omit “standard information statement”, substitute “private health
24 information statement”.

25 **12 Subsection 93-5(1)**

26 Omit “*standard information statement*”, substitute “*private health*
27 *information statement*”.

Schedule 4 Miscellaneous

Part 2 Information requirements

13 Subsection 93-5(2)

Omit “*standard information statements”, substitute “*private health information statements”.

14 Section 93-10 (heading)

Omit “standard information statements”, substitute “private health information statements”.

15 Paragraph 93-10(a)

Omit “*standard information statement”, substitute “*private health information statement”.

16 Paragraph 93-15(1)(a)

Omit “*standard information statement”, substitute “*private health information statement”.

17 Subsection 93-20(1)

Omit “*standard information statement”, substitute “*private health information statement”.

18 Paragraph 93-20(2)(b)

Omit “*standard information statements”, substitute “*private health information statements”.

19 Paragraph 93-20(2)(d)

Omit “standard information statement”, substitute “private health information statement”.

20 Subsection 93-20(5)

Omit “(1),”.

21 Section 96-1 (heading)

Omit “standard information statements”, substitute “private health information statements”.

22 Section 96-1

Omit “*standard information statements”, substitute “*private health information statements”.

1 **23 Section 96-5 (heading)**

2 Omit “**standard information statements**”, substitute “**private health**
3 **information statements**”.

4 **24 Section 96-5**

5 Omit “*standard information statements”, substitute “*private health
6 information statements”.

7 **25 Section 96-10 (heading)**

8 Omit “**standard information statements**”, substitute “**private health**
9 **information statements**”.

10 **26 Section 96-10**

11 Omit “*standard information statements”, substitute “*private health
12 information statements”.

13 **27 Clause 1 of Schedule 1**

14 Insert:

15 *private health information statement* is defined in section 93-5.

16 **28 Clause 1 of Schedule 1 (definition of *standard information***
17 ***statement*)**

18 Repeal the definition.

19 **29 Clause 1 of Schedule 1 (definition of *up to date*)**

20 Repeal the definition, substitute:

21 *up to date*, in relation to a *private health information statement, is
22 defined in subsection 93-1(2).

Schedule 4 Miscellaneous

Part 3 Benefit requirements according to class of hospital

Part 3—Benefit requirements according to class of hospital

Private Health Insurance Act 2007

30 After section 121-7

Insert:

121-8 Application for inclusion of hospital in a class

- (1) A person may apply to the Minister for a *hospital to be included in a class set out in the Private Health Insurance (Health Insurance Business) Rules.
- (2) The application must be:
 - (a) in the *approved form; and
 - (b) accompanied by any application fee imposed under the Private Health Insurance (Health Insurance Business) Rules.

121-8A Minister to decide application

- (1) The Minister must consider whether a *hospital to which an application relates satisfies the assessment criteria set out in the Private Health Insurance (Health Insurance Business) Rules.
- (2) If the *hospital satisfies the assessment criteria, the Minister must, within 60 days after the day the application is made:
 - (a) include the hospital in a class set out in the Private Health Insurance (Health Insurance Business) Rules; and
 - (b) notify the person, in writing, of:
 - (i) the hospital's inclusion in a class set out in the Rules; and
 - (ii) the day that the hospital is included in that class and the day that the hospital's inclusion in that class ends.
- (3) If the *hospital does not satisfy the assessment criteria, the Minister must, within 60 days after the day the application is made:
 - (a) notify the person, in writing, of that fact; and

1 (b) provide reasons for the decision.

2 Note: A decision that a hospital does not satisfy the assessment criteria set
3 out in the Private Health Insurance (Health Insurance Business) Rules
4 is reviewable under Part 6-9.

5 **121-8B Period of inclusion of hospital in a class**

6 The inclusion of a *hospital in a class set out in the Private Health
7 Insurance (Health Insurance Business) Rules:

- 8 (a) comes into force on the day specified in the notice referred to
9 in subparagraph 121-8A(2)(b)(ii); and
10 (b) expires on the day specified in that notice, unless it is
11 revoked earlier.

12 **121-8C Revocation of inclusion of hospital in a class**

13 The Minister may revoke the inclusion of a *hospital in a class set
14 out in the Private Health Insurance (Health Insurance Business)
15 Rules if the Minister considers that the hospital ceases to satisfy
16 the assessment criteria set out in the Rules.

17 Note: A decision to revoke the inclusion of a hospital in a class set out in the
18 Private Health Insurance (Health Insurance Business) Rules is
19 reviewable under Part 6-9.

20 **121-8D Private Health Insurance (Health Insurance Business) Rules**

21 The Private Health Insurance (Health Insurance Business) Rules
22 may:

- 23 (a) for the purposes of this Part and Division 72—set out one or
24 more classes of *hospital; and
25 (b) impose an application fee for the purposes of section 121-8;
26 and
27 (c) set out assessment criteria for including a hospital in a
28 particular class; and
29 (d) set out matters of a transitional nature relating to the current
30 arrangements for hospitals and the new application process
31 provided for by section 121-8.

32 **31 Section 328-5 (after table item 4A)**

33 Insert:

Schedule 4 Miscellaneous
Part 3 Benefit requirements according to class of hospital

1

5 To decide that a *hospital does not satisfy section 121-8A
the assessment criteria set out in the Private
Health Insurance (Health Insurance
Business) Rules

6 To decide to revoke a *hospital’s inclusion section 121-8C
in a class set out in the Private Health
Insurance (Health Insurance Business) Rules

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**PRIVATE HEALTH INSURANCE LEGISLATION AMENDMENT
BILL 2018**

GUIDE TO THE EXPOSURE DRAFT

March 2018

PRIVATE HEALTH INSURANCE LEGISLATION AMENDMENT BILL 2018

INTRODUCTION

The purpose of this Guide is to assist readers of the exposure draft of the *Private Health Insurance Legislation Amendment Bill 2018* released on 5 March 2018. The Guide focuses on the key provisions in the Bill and explains how they will operate.

The descriptions of the provisions below are not exhaustive. A more detailed description will be included in the Explanatory Memorandum which will accompany the Bill when it is introduced into the Parliament.

BACKGROUND

On 13 October 2017, the Government announced reforms to private health insurance designed to simplify private health insurance and make it more affordable for consumers. The package consists of the following reforms:

- Product design reforms, including:
 - A new system for categorising health insurance products (Gold/Silver/Bronze/Basic product categories);
 - Enhancing mental health support to improve patient access to mental health services;
 - Establishing the Improved Models of Care Working Group to provide advice on improving the funding arrangements for private health insurance funded mental health and rehabilitation services;
- Introducing standard clinical definitions;
- Improved access to travel and accommodation benefits for regional and rural areas;
- Strengthening the powers of the Private Health Insurance Ombudsman;
- Establishing the Ministerial Advisory Committee on Out-of-Pocket Costs to consider best practice models for transparency of out-of-pocket costs;
- Information provision reforms, including upgrading the Government's website (privatehealth.gov.au) and the development of a minimum data set for consumers;
- Allowing private health insurers to offer discounted private hospital cover to people aged 18 to 29;
- Prostheses List benefit reductions;
- Increasing maximum excess levels;
- Changing coverage for some natural therapies; and
- Second-tier administrative reforms.

The private health insurance reform package was the result of extensive consultation, including through the Private Health Ministerial Advisory Committee.

OUTLINE OF THE BILL

The proposed Bill will amend the *Private Health Insurance Act 2007* (“the PHI Act”), *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999*, *Medicare Levy Act 1986*, *Ombudsman Act 1976* and the *Age Discrimination Act 2004*.

The measures contained in the Bill will:

- increase maximum excess levels for products providing an exemption from the Medicare levy surcharge;
- allow for aged-based premium discounts for hospital cover;
- strengthen the powers of the Private Health Insurance Ombudsman;
- allow private health insurers to cover travel and accommodation costs as part of a hospital product for people attending health services;
- improve information provision for consumers; and
- reform the administration of second tier default benefits arrangements for hospitals.

PRIVATE HEALTH INSURANCE RULES

‘Private Health Insurance Rules’ are referred to throughout this Guide. This is a reference to subordinate legislation that is made by the Minister, or the delegate of the Minister, in the form of Private Health Insurance Rules under Division 333 of the PHI Act. These are legislative instruments and are subject to parliamentary disallowance.

A number of the reforms will require amendments to the Private Health Insurance Rules to:

- give effect to Gold/Silver/Bronze/Basic product categories and standardised clinical definitions;
- remove benefits for natural therapies;
- set the detailed framework for second-tier eligibility, including any application fee, and aged-based premium discounts for hospital cover;
- provide requirements for the Private Health Information Statement; and
- increase Complaints Levy funding for the Private Health Insurance Ombudsman.

The required amendments to the Private Health Insurance Rules are yet to be drafted and will be made following the passage of this Bill.

NOTES ON PROVISIONS**SCHEDULE 1 – INCREASING MAXIMUM EXCESS LEVELS**

Amendments in this schedule increase the maximum excess levels that are permitted for a policy to exempt the holder from the Medicare levy surcharge, and move the statement of these maximum excesses from taxation legislation to the PHI Act.

The amendments also remove transition provisions designed to deal with the replacement in 2007 of the concept of “applicable benefit arrangements” under the

National Health Act 1953 with the concept of a “complying health insurance policy” under the PHI Act.

The amendments also remove the grandfathering provision that provide an exemption from the Medicare levy surcharge for individuals who had policies with excesses greater than the maximum excess who have been insured continuously since May 2000 as long as their excess amount has not increased since that time. This exemption from the Medicare levy surcharge will no longer be available.

SCHEDULE 2 – DISCOUNTED HOSPITAL COVER PRODUCTS FOR 18-29 YEAR OLDS

This Schedule will allow insurers to offer products which provide discounted hospital cover to people aged 18 to 29 from 1 April 2019.

It will not be mandatory for insurers to offer discounted products.

The amendments alter the definition of “improper discrimination” in section 55-5 of the PHI Act to allow age-based discounts in accordance with Private Health Insurance Rules made under section 66-5.

The parameters of the allowable age based discount will be provided in the Private Health Insurance Rules.

The Bill seeks to amend the Age Discrimination Act to allow for these discounts to be made available to younger people.

SCHEDULE 3 – PRIVATE HEALTH INSURANCE OMBUDSMAN’S POWERS

This schedule amends the *Ombudsman Act 1976* to empower the Private Health Insurance Ombudsman (PHIO) to conduct inspections and audits at the premises of a private health insurer or private health insurance broker.

The PHIO may at any reasonable time of the day enter premises:

- occupied by a private health insurer or broker, or
- occupied by a person predominantly for the purpose of performing services for, or on behalf of a private health insurer or broker, or
- a place where the documents or other records relating to a private health insurer or broker or the carrying on of health insurance business are kept

and inspect any document or other records to:

- verify evidence provided in response to a complaint; or
- ensure that a private health insurer or broker has complied with responsibilities in relation to complying health insurance policies or complying health insurance products.

The PHIO may also take extracts from or make copies of documents or other records.

The occupier or person in charge of the premises commits an offence if they do not provide the PHIO with reasonable facilities and assistance for the effective exercise of these powers.

After exercising these powers the PHIO may make recommendations to private health insurers or brokers to take a specific course of action to ensure compliance with their responsibilities in relation to complying health insurance policies or complying health insurance products; or to make changes to their practices or procedures so as to ensure their responsibilities in relation to complying health insurance policies or complying health insurance products.

SCHEDULE 3 – MISCELLANEOUS

Part 1 – Benefits for travel and accommodation

These amendments will allow insurers from 1 April 2019 to offer travel and accommodation benefits under hospital cover instead of only under general treatment policies. This change allows travel and accommodation benefits to be included in risk equalisation calculations, providing an incentive for insurers to offer these benefits as it will allow them to better spread their risk.

It will not be mandatory for private health insurers to offer travel and accommodation benefits under either hospital or general treatment products.

Part 2 – Information requirements

A ‘Private Health Information Statement’ will replace the current ‘Standard Information Statement’ as the required method by which an insurer must provide information to consumers.

The Standard Information Statements will be discontinued from 1 April 2019 and insurers will be required to maintain up to date information about complying health insurance products in the form of a Private Health Information Statement, the requirements for which will be set out in the Private Health Insurance Rules.

Part 3 – Benefit requirements according to class of hospital

Under existing arrangements, an industry-based Second Tier Advisory Committee is responsible for receiving applications from private hospitals and determining their eligibility to receive second-tier default benefits provided in schedule 5 of the Private Health Insurance (Benefit Requirements) Rules.

These amendments establish a legislative framework for the Minister to assess and determine whether or not a private hospital is eligible to be included in a class of hospitals eligible for second-tier default benefits.

Under the new arrangements, a person can apply to the Minister for a hospital to be included in a class set out in the Private Health Insurance Rules. The application must be accompanied by any application fee set out in the Private Health Insurance Rules.

The Minister must consider the application to determine whether a hospital satisfies the assessment criteria set out in the Private Health Insurance Rules, and notify the applicant accordingly. A negative decision may be reviewed by the Administrative Appeals Tribunal.

If a hospital satisfies the assessment criteria, it is included in a class for the period determined by the Minister. If the Minister considers that the hospital has ceased to meet the assessment criteria, she or he may revoke its inclusion in the class. This decision may be reviewed by the Administrative Appeals Tribunal.

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NOT FOR FURTHER DISTRIBUTION



4 May 2018

Secretariat
Private Health Insurance Taskforce
Email : PHIConsultation@health.gov.au

Dear Secretariat

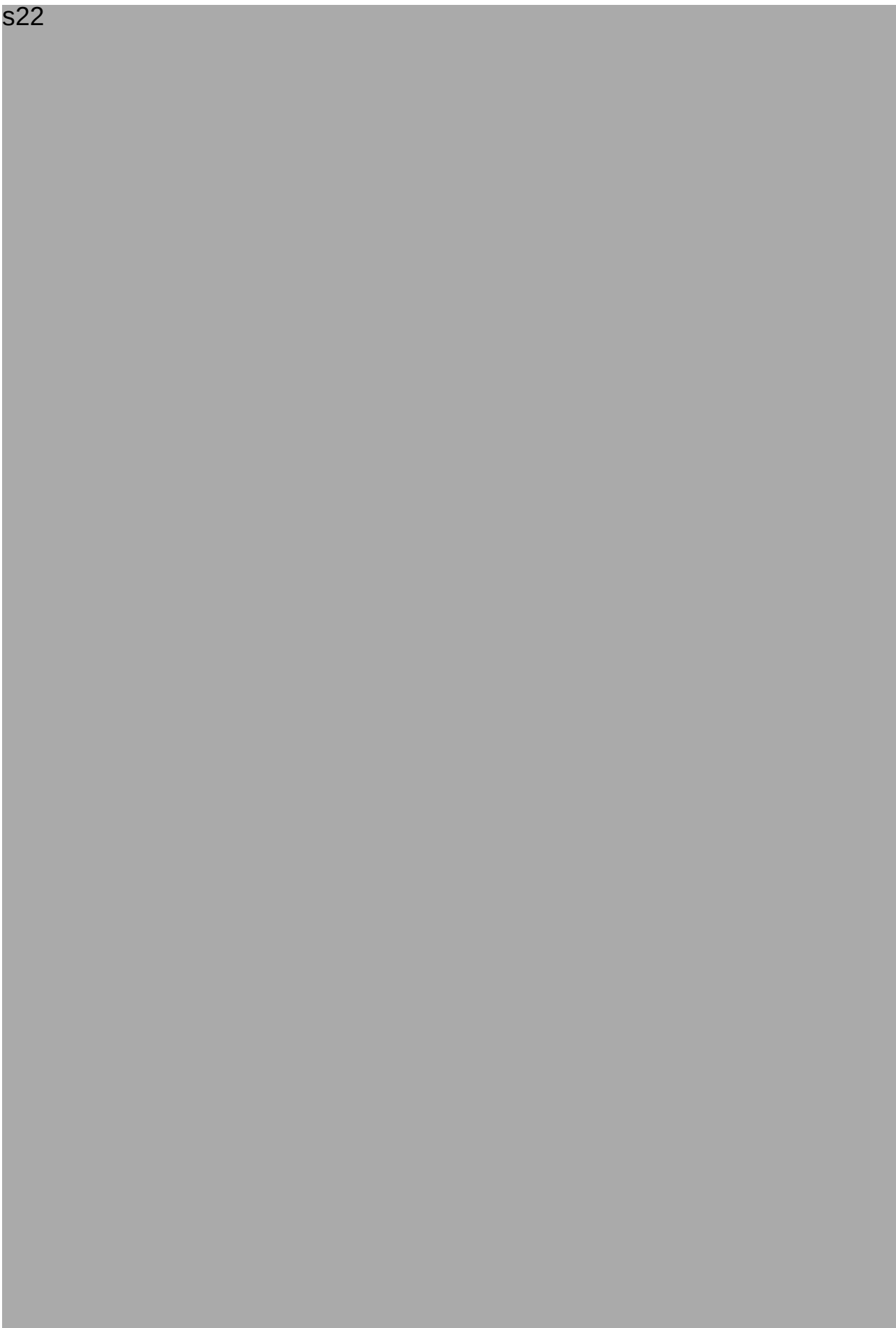
Thank you for the opportunity to provide feedback on the clinical definitions and proposed Gold, Silver, Bronze and Basic frameworks.

s22

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COMMERCIAL IN CONFIDENCE

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COMMERCIAL IN CONFIDENCEs22
**Clinical Definition Categories**

- We maintain it is not appropriate for podiatric surgery to form part of the clinical definitions for the GSB categorisation. This is because no MBS item numbers are payable for these services and consumers will be exposed to large out of pocket expenses (e.g. theatre fees, specialist fees etc.) which would clearly be at odds with the Department's policy reasons underlying the proposed GSB framework and the consumers perception of coverage and services available under a Gold or Silver product classification.

As previously submitted, the inclusion of podiatric benefits will render many comprehensive products to the Bronze category. **We do not support the inclusion of podiatric surgery in the clinical definitions and recommend it be removed. If this category is to be maintained, it should only apply to Gold level cover.**

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Should you wish to discuss any of the feedback in further detail, please contact s47F

s47F

Yours sincerely

s47F

**Executive General Manager – Private Health Insurance
Australian Unity**

Attachment 1

Clinical Definition Category	Feedback		
	Gold, Silver, Bronze, Basic	MBS Mapping	General

s22			
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Clinical Definition Category	Feedback		
	Gold, Silver, Bronze, Basic	MBS Mapping	General
s22			

Clinical Definition Category	Feedback		
	Gold, Silver, Bronze, Basic	MBS Mapping	General

s22			
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Clinical Definition Category	Feedback		
	Gold, Silver, Bronze, Basic	MBS Mapping	General
s22			

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Clinical Definition Category	Feedback		
	Gold, Silver, Bronze, Basic	MBS Mapping	General
s22			
Podiatric Surgery provided by an accredited podiatric surgeon	We do not support the inclusion of podiatric surgery as part of the GSB framework on the basis Medicare benefits are not payable for these services and consumers will subsequently incur large out of pocket expenses for this type of surgery. If this category is to remain, it should only be linked to Gold cover.		

phiconsultation@health.gov.au

4 May 2018

Dear **S47** and Team,

Response regarding Draft Clinical Definitions

Teachers Health (TH) welcomes the opportunity to respond to the proposed standard clinical definitions.

Our review has highlighted the following key elements:

1. The proposal to duplicate MBS items across standard clinical definitions will have a major impact on the payment of hospital claims. In addition, the 'General note' that some procedures will be covered if they are delivered as part of an MBS item listed in the same category will also have a significant impact on the payment of hospital and medical claims, delaying some payments while waiting for the claim relating to the principal procedure.

In addition, if MBS items are in multiple categories, it will be confusing for the policyholder if they are covered for the same item in one category, but not the other. For example - MBS 345838 (CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition), is in **Dialysis for chronic kidney disease** (only required to be covered on Gold) as well as **Digestive system conditions and services** (which is required on Bronze).

2. With the proposed categories, TH seek clarification on whether restrictions are allowed (for the elements marked with an "x"). TH currently offers restricted benefits in many areas, and there will be a major impact on our operations and detrimental changes to our members if no restrictions are allowed.

We note the DOH comments for SCD for Rehabilitation, *"The department is considering the issue of restrictions as part of the ongoing development of the standard clinical definitions and products categories"*. This issue will impact on all SCDs.

3. There are several MBS items that are not included in the standard clinical definition categories and where they possibly should be. If these items are not included in the SCD categories, are they to be included in the General surgery items? Do private health insurers have to cover these items?
4. Future changes to MBS items when new, deleted or changed descriptions occurs. Who, how and when will this be actioned for the SCDs?
5. There will be potential issues for members when eligibility checks are conducted with multiple MBS items covering different SCDs. It could make a difference as to whether the member is advised they are covered, depending upon which MBS item is the "primary diagnosis".

We're
for
teachers

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68 Macquarie Street, Parramatta NSW 2150
142 Beaumont Street, Hamilton NSW 2303
52 Bridge Road, Richmond VIC 3121
26 Flinders Street, Adelaide SA 5000



6. It is recommended that podiatry is limited to Gold as there are relatively few podiatric surgeons and hence benefits paid in respect of this item.
7. It is inconsistent that Miscarriage and Termination are in Bronze level while Pregnancy is in Gold.

In addition, TH has some direct comments on the proposed groupings, as detailed in tabular format on the following pages.

Should you have any questions in relation to this matter, please do not hesitate to contact me at

s47F

Yours sincerely,

s47F

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Response to Attachment A-Alignment of procedures to Standard Clinical Definitions
These issues have been included below in the Standard Clinical Definitions (SCD) table.

Standard clinical definitions table

Clinical Definition	DoH Feedback	TH comments
Rehabilitation	s22	
Psychiatric services		
Palliative care		
Heart and heart-related conditions and services		
Vascular and vascular-related conditions and services		
Lung and lung-related conditions and services		
Brain and brain-related conditions and services		
Eye and eye-related conditions and services (cataracts listed separately under cataract procedures)		

Clinical Definition	DoH Feedback	TH comments
Cataract procedures	s22	
Pregnancy and birth related conditions and services (neonates are covered under this category for single parent and family policies, terminations and miscarriages are listed separately)		
Female reproductive conditions and services		
Miscarriages and termination of pregnancy services		

Clinical Definition	DoH Feedback	TH comments
Assisted reproductive services	s22	
Joint replacements and spinal fusion		
Joint reconstructions		
Bone and joint conditions & services (joint replacements are listed as a separate category, joint reconstructions are listed separately and spine is listed separately under back, neck and spine)		

Clinical Definition	DoH Feedback	TH comments
Back, neck and spine conditions and services (spinal fusion is listed separately under Joint replacements and spinal fusion)	s22	
Ear, nose and throat conditions and services (hearing loss listed separately and tonsils, adenoids and grommets are listed)		
Implanted devices for hearing loss surgery		
Tonsils, adenoids and grommet surgery		
Dialysis for chronic kidney disease		

Clinical Definition	DoH Feedback	TH comments
Kidney, bladder and male reproductive conditions and services (dialysis is listed separately under dialysis for chronic kidney disease)	s22	
Digestive system conditions and services (hernia and appendicectomy is listed separately)		
Hernia repair and appendicectomy		
Weight loss surgery or procedures		

Clinical Definition	DoH Feedback	TH comments
Endoscopy	s22	
Breast surgery (non-medically necessary surgery is not covered under private health insurance)		
Chemotherapy, radiotherapy and immunotherapy for cancer		
Plastic and reconstructive surgery (non-medically necessary cosmetic surgery is not covered under private health insurance)		
Plastic and reconstructive surgery of congenital defects and conditions		
Surgery for skin and skin lesions		
Dental surgery		

Clinical Definition	DoH Feedback	TH comments
Insulin pumps	s22	
Management of ongoing (chronic) pain		
Podiatric surgery provided by an accredited podiatric surgeon Sleep studies	i. The <i>Private Health Insurance Act 2007</i> includes podiatric surgery as hospital treatment (Section 121.5) and therefore the category will remain in the standard clinical definitions. ii. No MBS items have been assigned to this category. In compliance with current regulations, insurers are only required to pay default accommodation costs. It is not appropriate to refer to out-of-pocket costs in the standard clinical definitions.	
Blood and blood-related conditions and services	s22	

Comments on the Draft Hospital Product Design

We have suggested alternative names to some of the categories based on the fact that we pay for claims based on procedures and not conditions. Often at the time of the claim we do not have information to verify what condition was being treated (this information may only arrive months later, if at all). It is therefore more accurate and understandable to talk about "procedures and services" rather than "conditions and services".

Hospital treatments & services by product category Basic Bronze Silver Gold	Suggested Alternative Name	Comments
s22		

s22



Podiatric surgery provided by an accredited podiatric surgeon		This category should be removed. Podiatric "surgeons" are not medically qualified surgeons and are inadequately trained compared with orthopaedic surgeons. We maintain that promoting this service is misleading and potentially harmful to members.
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s22



s22

