

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 out 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 policies 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.

Susan Azmi
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3 May 2018

s47F

Senior Policy Adviser, Medical Practice
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By email: s4 @ama.com.au

Dear s47F ,

Re: Clinical Definitions for PHI

Thank you for the opportunity to contribute feedback regarding the Department's consultation on clinical definitions for private health insurance.

Our first response must be to protest the very limited amount of time they have allowed for this stage of the consultation. While we have gathered some feedback and prepared a limited response, we feel that, as these issues have the potential to have significant and wide-ranging impact on the delivery of healthcare for the Australian public, the relevant deadlines seem unlikely to allow the considered responses required. With this in mind, we look forward to the Department's advice on how further feedback can best be delivered.

In addition to the issues raised below, I would also refer the Department to the Spine Society of Australia's (SSA) submission and the attached correspondence from Australian Knee Society President s47F .

Our primary concerns relate to the splitting of different services relevant to the same patient or condition between different levels of cover, leading to economic influences on decisions of patient care that should only be guided by concern for patient outcomes. Two examples are provided below; further detailed examples focusing on specific issues relating to the classification and placement of spinal fusion are available in the accompanying SSA submission.

Where such a split occurs between several possible treatments in response to a diagnosis, and some of those treatments are covered by the patient's class of treatment but others are not, the pressure will be applied at the point of decision. It will inevitably be the case under this system that instances will arise where treating practitioners will be forced to choose between the treatment with the best evidence base and outcomes, and that which the patient can afford and receive quickly.

Example:

An elderly patient with long term silver-class private health insurance has to attend a casualty department after experiencing severe pain and restricted function around her right hip. The surgeon investigates



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and determines that she has a fractured neck of femur. There are two possible treatments to consider; the first, a reconstructive plates-and-screws procedure; the second, a hip replacement. Based on a thorough review of the patient's case, the surgeon knows that in this instance a hip replacement is the best-supported option. However, as joint replacements are only supported by gold-class insurance, that option requires transfer to a public hospital. The patient and her family are distressed as her health insurance does not cover an extremely common problem. There is no option but to transfer to a public hospital for further treatment. This involves a delay in treatment by surgeon not of the patient's choosing. This would involve a delay and this in turn may compromise surgical outcomes for the patient.

We trust that everyone agrees that putting patients and their treating practitioners in such a position would be unconscionable. In addition to subjecting treatment decisions to influences other than the best supported evidence for patient outcomes, the distress involved for patients and their families would inevitably lead to an increase in negative publicity around private health insurance, placing further stress on the already fragile public perception of its value proposition and also increasing the demand on public health resources

Where a service class-split occurs within a sequence of treatments, the first stages of investigation and treatment may be covered for a particular patient, but later developments may lead to a need for treatments that are not included in their coverage, necessitating a transfer to a public hospital.

Example (see SSA submission for further detail):

A patient is admitted to a private hospital for investigation and treatment of disseminated malignancy, which is covered by his class of insurance. In hospital, paraparesis develops, requiring decompression and stabilisation. However, spinal fusion is not covered in his class of insurance. As a result, he must be transferred to a public hospital in order to afford treatment. The delay in treatment results in a greatly reduced outcome, prolonged suffering and a greater chance of complications for the patient.

Again, this is a situation we assume all parties would wish to avoid.

While these examples refer to specific aspects of the draft documentation provided, the issue of cross-class service splits would seem inherent in the nature of the proposed system – that it uses services as its foundation predisposes it to such problems. The current structure will lead to treatment driven by item numbers, not by the best available evidence for the best possible patient outcomes.

If the system was instead structured around the pathology or situation requiring treatment, this issue could be resolved. Patients with a particular



condition or disease for which their level of insurance provides coverage would be able to work with their consultant to decide the best treatment plan based on the best evidence available, without the intrusion of economic factors that do not align with the patient's best interests.

Such a revision would also better align the system with the project's stated aims of consumer understanding, consistency and certainty; consumer understanding, as customers reviewing private health insurance would seem more inclined to understand problems and conditions they might encounter than the specific variations of treatment for those conditions; and consistency and certainty about coverage, as situations where some possible treatments for a particular diagnosis are covered by some levels of cover but others are not, provide neither.

A further note on behalf of the Australian Orthopaedic Foot and Ankle Society: we note the inclusion of references to "podiatric surgery provided by an accredited podiatric surgeon" and must echo previous sentiment evident in Attachment B. There are no current options for valid accreditation of a 'podiatric surgeon' in Australia, as we have previously explained in related submissions to government bodies. Despite the Department's decision that 'podiatric surgery's inclusion in the *Private Health Insurance Act 2007* determines its inclusion in this system, the lack of any attributed item numbers would seem to reinforce the anomalous nature of its presence. We remain concerned that, without at least acknowledgement of this fact, there is a risk to consumer understanding in the suggested alignment of surgery performed by operating podiatrists with that of the services of properly trained and accredited specialist surgeons.

Again, I must reiterate that the timeframe given to this important phase of consultation is alarmingly brief. Matters that have the potential to so greatly affect outcomes for Australian patients must be reviewed with appropriate consideration and consultation, and the voices of Australian practitioners – the people most intimately acquainted with the delivery of the services in question, and the circumstances in which they are delivered – can provide a vital perspective.

Further feedback will be forthcoming, and we look forward to engaging in more considered and productive consultation moving forward.

Yours sincerely,

s47F

s47F

President

s22

From: s22 on behalf of PHI Consultation
Sent: Sunday, 6 May 2018 5:34 PM
To: s22
Cc: s22; s22
Subject: FW: Clinical Definitions - consultation process [SEC=UNCLASSIFIED]

Categories: Filed to Multiple

[For consideration – product design comments](#)

From: s47F [mailto:s47F@bupa.com.au]
Sent: Friday, 4 May 2018 3:46 PM
To: PHI Consultation
Cc: s47F; s47F; s47F
Subject: RE: Clinical Definitions - consultation process [SEC=UNCLASSIFIED]

Dear Secretariat,

Thanks again to the Department for their ongoing consultations on the PHI reforms.

We would like to provide you with the below feedback from Bupa for your consideration regarding the latest draft hospital product categories and standard clinical definitions (including MBS item mapping).

s22

Draft Hospital Product Design table

s22

2. Podiatric surgery should not be included in any clinical definitions/category.

s22

s22

Kind regards,

s47F

s47F, Government Relations and Public Policy Manager

Bupa, 33 Exhibition Street, Melbourne, VIC 3000

M s47F E s47F @bupa.com.au W bupa.com.au/healthandcaring



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From: PHI Consultation <PHIconsultation@health.gov.au>

Date: Monday, 16 April 2018 at 11:45 am

Cc: PHI Consultation <PHIconsultation@health.gov.au>

Subject: Clinical Definitions - consultation process [SEC=UNCLASSIFIED]

Good morning

The Department of Health is consulting with interested stakeholders on the draft standard clinical definitions for private health insurance hospital treatment policies.

The standard clinical definitions take effect from 1 April 2019 and are designed to increase consumer understanding and improve transparency of health insurance. The standard clinical definitions will cover all treatments and services offered under hospital treatment policies. All insurers will be required to use these terms (and no others) in all materials – to provide consistency and give consumers certainty about coverage. If an insurer lists a category as included in a product, the insurer must provide cover for all MBS items listed in that category (i.e. no partial cover). Further background is provided at [Attachment A](#).

The attached table ([Attachment B](#)) contains the MBS items for each definition and a summary of the feedback received during the previous consultation process. The department would also like advice on specific issues in regards to the list of MBS items as detailed in [Attachment A](#).

In addition to the introduction of standard clinical definitions, the Government has announced that from 1 April 2019 all private health insurance products will be classified as Gold, Silver, Bronze or Basic. The Gold, Silver, Bronze or Basic classification will use the standard clinical definitions. To assist in your

analysis of the clinical definitions, the draft product category grid at Attachment C shows the proposed minimum standards for products to be offered in each category.

The department requests feedback by email to PHIConsultation@health.gov.au. The consultation process is open until 5pm, 27 April 2018.

Kind regards

Secretariat
Private Health Insurance Taskforce

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Private Healthcare Australia
Better Cover. Better Access. Better Care.



Submission to Department of Health on Private Health Insurance
Reforms: Part 5
Hospital product categories and clinical definitions

May 2018

Contact:

s47F

Thank you for the opportunity to comment on the draft hospital product categories and clinical definitions.

Comments on Attachment A: alignment of procedures to standard clinical definitions

s22



Comments on Attachment B: table of clinical definitions

s22



Comments on Attachment C: draft hospital product categories

s22



- **Podiatric surgery:** PHA continues to support the exclusion of podiatric surgery from the minimum product requirements because the service does not have an MBS item number.

s22



s22





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Response to the Proposed Changes to Minimum Product Requirements and Clinical Definitions

Overview

This report contains feedback from both nib and Grand United Corporate Health Ltd (GUCHL) regarding the proposed Minimum Product Requirements and Clinical Definitions.

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Response to Attachment A (Alignment of Procedures)

s22



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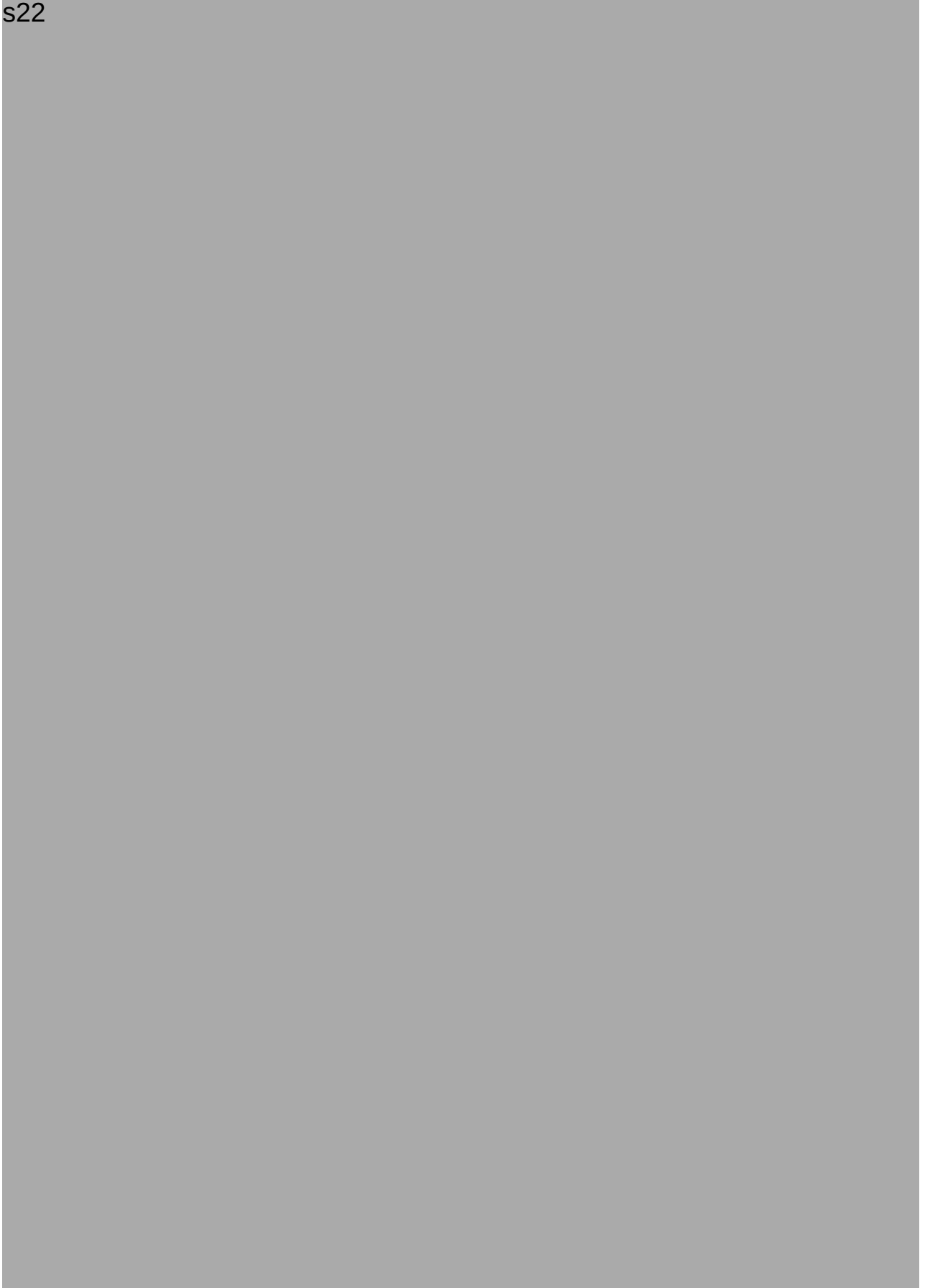
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Podiatric Surgery

In line with nib and GUCHL's previous feedback, we recommend that Podiatric Surgery is not included in the Clinical Definitions. The inclusion of Podiatric Surgery is likely to mislead consumers as it indicates coverage will be in line with that of the other Clinical Definitions. Podiatric Surgery is often associated with large out of pockets as there is no MBS and therefore no requirement to pay benefits for specialist fees. nib and GUCHL recommend that Podiatric Surgery is covered in line with the orthopaedic categories contained under Bone and Bone-related Conditions and Services.

s22





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42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA Submission: Department of Health Consultation on the draft standard clinical definitions for private health insurance hospital treatment policies

PHIConsultation@health.gov.au

4 May 2018

Background

The AMA has always advocated that maintaining and improving the value of private health insurance for consumers is vital for the future of private health care in Australia. The Australian health system is best served by a dual system of public and private care. The AMA understands that purchasing private health insurance is a significant financial commitment for many consumers and achieving value for money is very important.

Private health insurance is one of the most complex forms of insurance and the current complexity of product offerings has led many consumers to report that they do not understand what they are covered for.

Noting that a fundamental aim of the Private Health Insurance Ministerial Advisory Committee's (PHMAC) work is to build consumer confidence in the private health system and the insurance that underpins it, the AMA has a number of issues with the consultation on draft clinical definitions.

Summary

As a key participant on the PHMAC, the AMA knows exactly how critical changes to clinical definitions are to the overall private health insurance reform. Therefore, the short timeframe and process for seeking stakeholder feedback for this consultation on clinical definitions is unacceptable.

PHMAC has now been operating for more than a year, yet allowing a timeframe less than three weeks has not permitted wide consultation to inform appropriate allocation of clinical services under the proposed private health insurance categories and definitions. The AMA looks forward to advice from the Department on how future feedback on benefit coverage combined with the standardisation of clinical definitions will be considered.

Given the short timeframe permitted, the AMA has reviewed the current mapping for clinical issues at a high level only.

The most positive aspect of the methodology underpinning the introduction of the health insurance tiers *Basic*, *Bronze*, *Silver* and *Gold* is consumer certainty that if a treatment is listed as 'insured' on a policy this will mean all hospital accommodation, theatre, intensive care, nursing, ward drugs, prostheses, and diagnostic services costs will be fully insured during an admitted episode in a contracted hospital, or insured at 2nd tier rates in a private non-contracted hospital (outside CHIP restricted services). This of itself will go a long way to assisting consumers understand their insurance benefit entitlements.

However, the AMA considers significantly more work needs to be done to refine the allocation of standardised terminology and Medicare Benefit Schedule (MBS) item numbers to treatment categories, and the coverage offered by some of the categories, as outlined below.

The submission is structured to highlight issues related to:

- Consultation
- Mapping changes
- Attachment A - Feedback example issues from members (General / Specific)
- Attachment B - MBS use in contemporary private practice
- Attachment C – Previous issue with MBS items and PHI allocation
- Attachment D – Example mapping of coverage levels (current vs proposed)
- Attachment E – The submission by the Australian Orthopaedic Association

Further, while the AMA is represented on PHMAC, the AMA does not endorse the clinical definitions in their current form and reserves its right to provide further feedback as necessary.

Consultation

The AMA is disappointed with the consultation process, and in particular, that the mapping has not been undertaken via wider consultation with key stakeholders directly involved with administration of, or reform to the MBS.

Firstly, it is concerning for the AMA to learn that relevant Department of Health (Department) areas, including Medicare Benefits Division or MBS Provider Integrity Benefits Division (Compliance), were not consulted on the mapping. These internal Divisions can provide practical advice on item development, utility and claiming patterns of medical services.

Secondly, it seems counterproductive that amidst a parallel MBS Review which looks at appropriate use of the MBS services and how items combine to form a clinical pathway, that there has not been demonstrated consultation with the MBS Review Taskforce or the relevant clinical sub-committees, in order to transfer this knowledge into the clinical

definitions design. To further highlight the AMA's approach to the MBS process and how the AMA sees the interaction with the PHMAC process, please see **Attachment B**.

Alignment of MBS item numbers with clinical definitions for the purpose of private health insurance benefit coverage must be informed by consultation with clinical experts familiar with the MBS and its application. The AMA understands that the current consultation process has been limited to a select list of invited groups, which is not publicly available.

The allocation of MBS items to clinical definitions ultimately determines the value proposition of private health insurance, when a patient is covered for a service, and when a benefit will be received. The clinical definitions for privately insured patients impacts clinical scope of practice. This can influence where a patient is treated, the level of medical services provided and whether there is a private health insurance benefit paid for the service.

AMA cautions that this oversight will result in unexpected or increased patient out of pocket costs, therefore undermining the purpose of the PHMAC reforms, whilst negatively impacting the longstanding work of the MBS Review.

The AMA has spoken with a number of Colleges, Associations and Societies (CAS) over the consultation period, and we are not confident that the relevant clinical leaders across the CAS have been consulted in an in-depth manner within the current timeframe. Likewise the short timeframe has meant AMA has not been able to consult with its wider membership.

Transparency is critical to any large reform process and the AMA would expect that the broader CAS is extensively consulted with. To highlight this, **Attachment C** describes a recent example where an MBS Review, having been led by the relevant clinicians was completed and accepted by Government and the profession, only to be undermined by inappropriate Private Health Insurance classification.

Mapping

In relation to the mapping of MBS item numbers, more clarity is needed as to which MBS items have been included, excluded or shifted under the specific draft clinical definitions. MBS item structure is complex and it would be helpful if the background papers give a clear indication of approach used to classify the MBS items, particularly for those stakeholders not familiar with PHMAC's prior work.

The AMA also considers a full and thorough mapping exercise is needed to compare the proposed coverage by product category/tier with the existing health insurance product offering. Mapping the current product offering against the proposed new *Gold, Silver, Bronze, Basic* categories will assist PHMAC in understanding where consumers will lose coverage of items which they currently have, and where they can expect to see an improvement in their level of coverage. As far as AMA can see, this mapping work has not yet been done.

Attachment D represents the findings of a quick 'desktop' search of a number of private health insurance policies and their associated levels of coverage, contrasted with the proposed new tiers of insurance. It is by no means complete, and carries a number of caveats as outlined, so is provided to PHMAC Secretariat for illustrative purposes.

What it does highlight is that for a number of policies, their equivalent in the new schemes will result in a reduction of policy coverage for a range of conditions.

The AMA is concerned that the current consultation exercise is being driven only by cost consideration, and does not yet draw on the rigorous approach in place to support an evidence-based MBS.

For example, the inclusion of a procedure in the MBS Schedule is subject to the rigorous requirements of the Medical Services Advisory Committee (MSAC) process to determine what procedures should be covered, for what purpose and the specialty qualified to use the item.

The AMA is also concerned that through this closed consultation, for those stakeholders who have not had a 'seat at the PHMAC table', the draft definitions list will appear arbitrary. Without more detail as to the methods for allocating item numbers in the current consultation draft, stakeholder groups are not well placed to respond in an informed way.

For the AMA, this is particularly important as the AMA defers feedback relating to speciality items and their application to the relevant CAS, as we have with the MBS Review.

Contact

s47F



Enclosed attachments

- Attachment A - Feedback example issues from members (General / Specific)
- Attachment B - MBS use in contemporary private practice
- Attachment C - Previous issue with MBS items and PHI allocation
- Attachment D - Example mapping of coverage levels (current vs proposed)
- Attachment E - The submission by the Australian Orthopaedic Association

Attachment A

The following feedback illustrates the need for clinician review of the proposed MBS mapping. The comments represent a small sample from AMA committee members, many whom are renowned specialists in their field and have experience with MBS reviews and insurance policies.

Feedback from Members:

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Specific Issues

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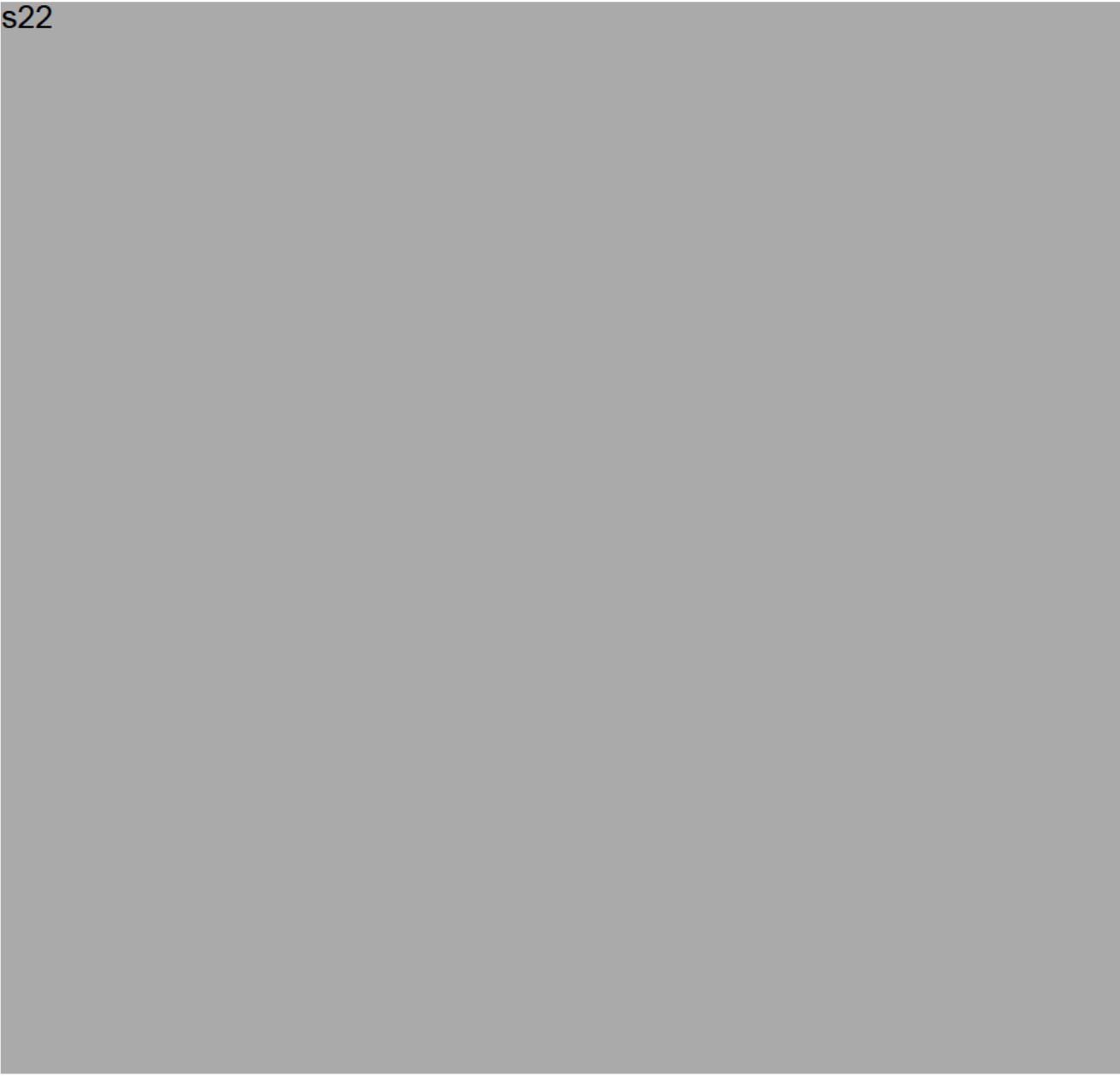
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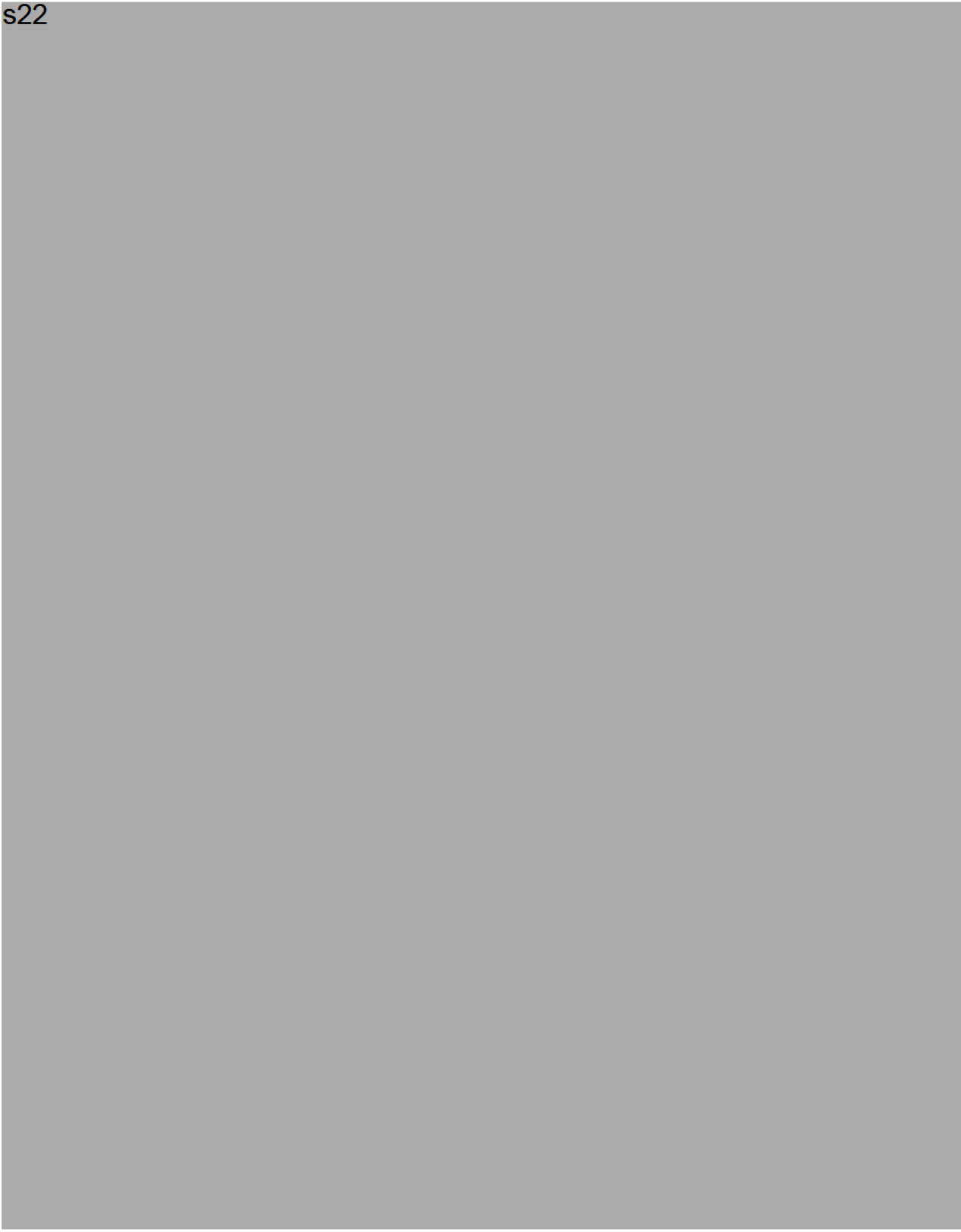


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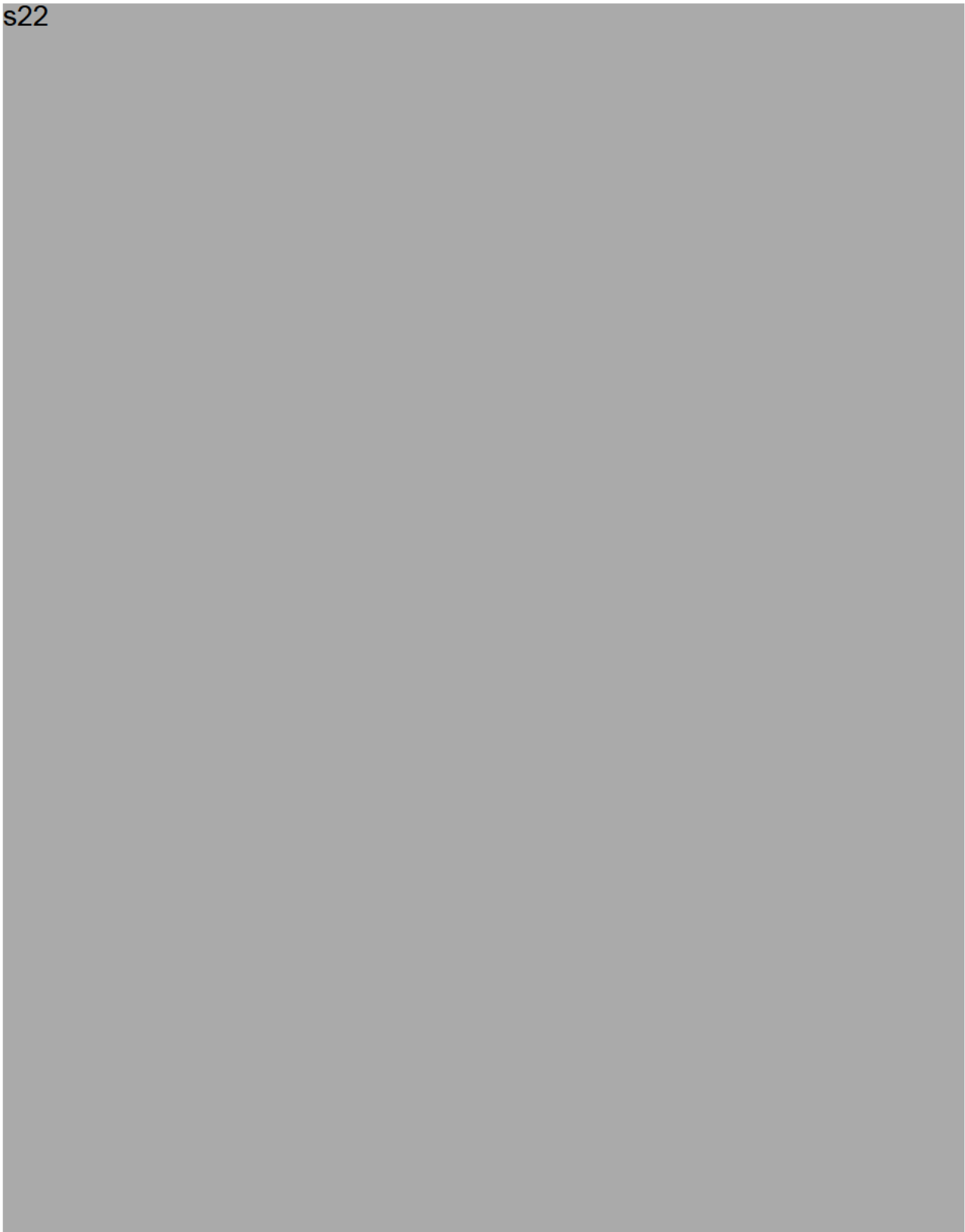
Attachment B

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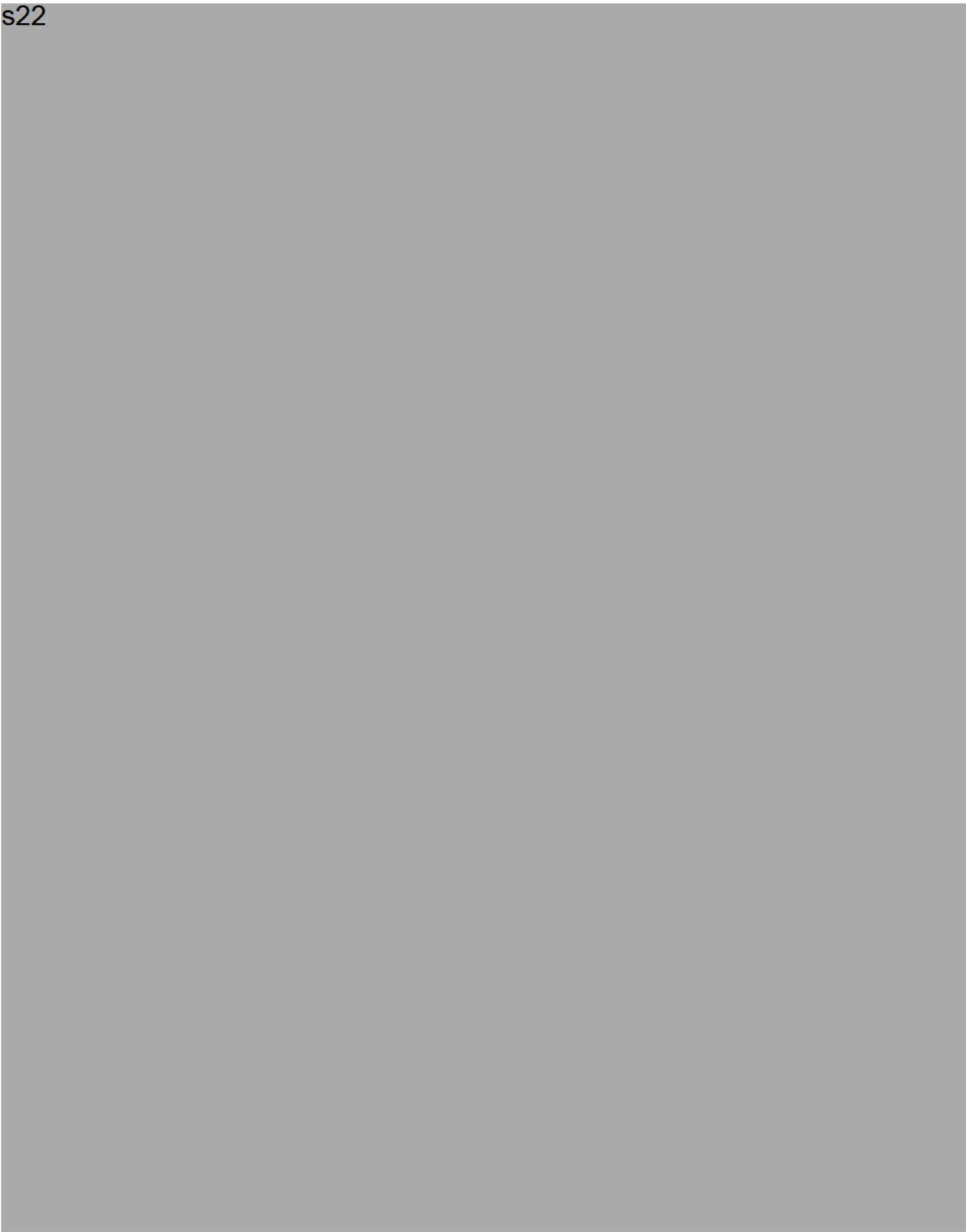
Attachment C

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Attachment D

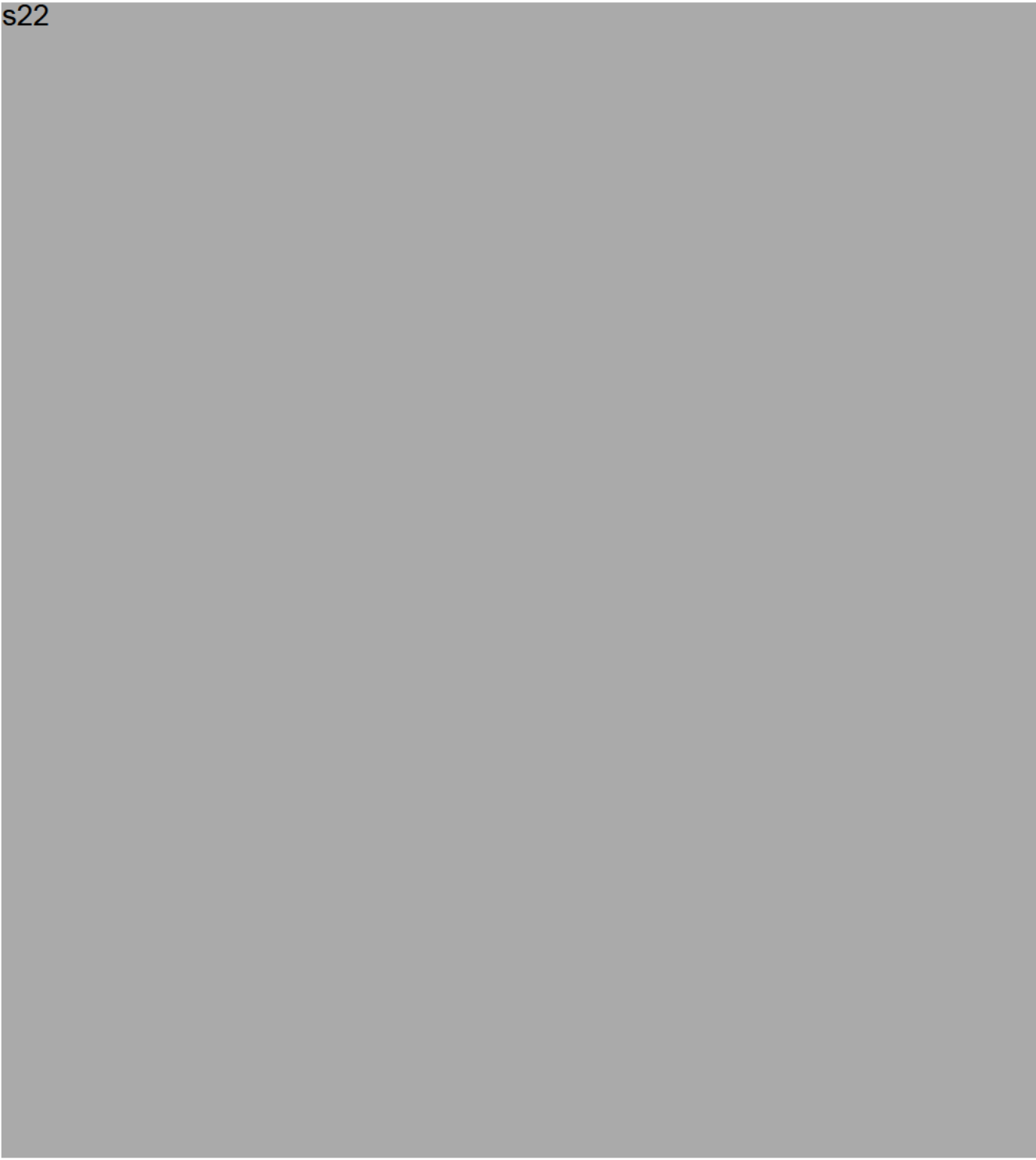
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Minjae Lee

Chief Executive Officer
and Company Secretary
Adrian R Cosenza

3 May 2018

s47F

Dear s47F,

Re: Clinical Definitions for PHI

Thank you for the opportunity to contribute feedback regarding the Department's consultation on clinical definitions for private health insurance.

Our first response must be to protest the very limited amount of time they have allowed for this stage of the consultation. While we have gathered some feedback and prepared a limited response, we feel that, as these issues have the potential to have significant and wide-ranging impact on the delivery of healthcare for the Australian public, the relevant deadlines seem unlikely to allow the considered responses required. With this in mind, we look forward to the Department's advice on how further feedback can best be delivered.

In addition to the issues raised below, I would also refer the Department to the Spine Society of Australia's (SSA) submission and the attached correspondence from Australian Knee Society President Bruce Caldwell.

Our primary concerns relate to the splitting of different services relevant to the same patient or condition between different levels of cover, leading to economic influences on decisions of patient care that should only be guided by concern for patient outcomes. Two examples are provided below; further detailed examples focusing on specific issues relating to the classification and placement of spinal fusion are available in the accompanying SSA submission.

Where such a split occurs between several possible treatments in response to a diagnosis, and some of those treatments are covered by the patient's class of treatment but others are not, the pressure will be applied at the point of decision. It will inevitably be the case under this system that instances will arise where treating practitioners will be forced to choose between the treatment with the best evidence base and outcomes, and that which the patient can afford and receive quickly.

Example:

An elderly patient with long term silver-class private health insurance has to attend a casualty department after experiencing severe pain and restricted function around her right hip. The surgeon investigates