Australian Government

Department of Health

Consultation paper: private health insurance reforms – second wave

December 2020

Consultation closes: Monday 8 February, 17:00 ACT local time

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INTRODUCTION

Australia has a mixed public and private model of health care funding and service delivery. Private health insurance (PHI) offers greater choice in the provision of treatment, coverage for some services not included under Medicare arrangements, and may offer shorter waiting times for some services.[1] The Australian Government is committed to ensuring consumers can access affordable, quality and timely health services through PHI alongside universal access to health services through Medicare.[2]

The Government's objectives for PHI are to promote affordability, quality, sustainability and greater choice for consumers.[3] In 2019, the Government implemented a package of reforms to address consumer concerns regarding the complexity and value of PHI. Changes included introducing easy to understand product tiers and clinical categories, new travel and accommodation benefits, clearer Private Health Information Statements, voluntary age-based discounts and an ability to upgrade mental health cover.[4] These reforms have contributed to the lowest annual premium increase in 19 years.[5]

The Minister for Health, the Hon Greg Hunt MP, has encouraged stakeholders to work collaboratively on further opportunities to improve the affordability and sustainability of PHI. During the course of 2020 the Department of Health engaged in bilateral discussions with various stakeholders on proposals for further reforms.

On 6 October 2020, the Government announced a package of PHI reforms that aims to make PHI more affordable for consumers by encouraging greater participation, particularly by younger Australians, and by providing greater flexibility for insurers to manage costs and fund services valued by their policy holders.[6]

This consultation paper is to assist the finalisation and implementation of the following reforms:

1. Increasing the age of dependents to encourage younger people and also people with a disability to maintain private health insurance;
2. Expanding home and community based rehabilitation care;
3. Expanding funding to at home and community based mental health care; and
4. Applying greater rigour to the certification for hospital admission.

In addition, the Government also announced funding for:

- External actuarial studies to ensure that the settings for Lifetime Health Cover and risk equalisation are optimal; and
- Expansion of the Medical Costs Finder website to include information on the fees of individual medical specialists.

Stakeholder engagement on these initiatives is being undertaking separately.

[1] Australian Government Department of Health, About private health insurance
[2] 2020-21 Portfolio Budget Statements – Budget Related Paper No. 1.7 – Health Portfolio
[3] 2020-21 Portfolio Budget Statements – Budget Related Paper No. 1.7 – Health Portfolio
[4] Australian Government Department of Health, Private health insurance reforms
[5] The Hon Greg Hunt MP, Media Release, 7 December 2019
[6] 2020-21 Portfolio Budget Statements – Budget Related Paper No. 1.7 – Health Portfolio ; The Hon Greg Hunt MP Media Release 6 October 2020 - Budget 2020-21; Fact Sheets: Budget 2020–21: Supporting our hospitals;

HOW TO LODGE A SUBMISSION

This consultation document is not a Regulatory Impact Statement but is intended to solicit information for the development and implementation of policy decisions. Genuine and timely consultation is an Australian Government requirement contained in Principle 4 of the Australian Government Guide to Regulatory Impact Analysis.

Feedback on these papers is requested by Monday 8 February, 17:00 ACT local time by email to the PHI Consultation mailbox: phiconsultation@health.gov.au. Feedback received after this date may not receive detailed consideration.

The Department is seeking information and comment on any issues that respondents consider relevant to the proposed reforms. Respondents are free to comment on issues in addition to the specific matters raised in this consultation paper. The Department welcomes all feedback, including additional measures to address issues detailed in this paper.

Submissions may range from a brief comment or short letter outlining your views on a particular topic to a much more substantial document covering a range of issues. Where possible, respondents should support their submission with evidence.

Each submission and comment, except where supplied in confidence, will be considered for publication on the Department's website, and if published, remain indefinitely as a public document.

If respondents would like their feedback to remain confidential, please mark it as such, or indicate which sections should be confidential, and which are appropriate for publication. It is important to be aware that confidential feedback may still be subject to access under freedom of information laws. The freedom of information process usually includes consultation with the respondents prior to a decision about the release of information.

OVERVIEW – FOCUS OF PROPOSED REFORMS

The first wave of reforms in 2019 addressed consumer concerns regarding the complexity and value of PHI. This second package of reforms is focussed on encouraging greater PHI participation through measures that enable private health insurers and healthcare providers to provide additional value to policyholders, improve the affordability of policies and underpin the long-term sustainability of the PHI sector.

Improving participation rates, particularly amongst young Australians

Private health system stakeholders have identified that measures to encourage additional private health insurance membership, particularly amongst young people, will significantly contribute to improved affordability of PHI and, as a consequence, the sustainability of the sector.

Removing perceived barriers to improved models of care

Discussions with stakeholders indicate that some privately insured patient services currently delivered in hospital could be appropriately provided out of hospital.[7] It is acknowledged that consumers often prefer some or all of their treatment and/or rehabilitation to occur in the comfort of their home or in a community based care setting where this is clinically appropriate.

Although insurers, under certain conditions, have been able to pay for a range of services outside of hospital since the 2007 Broader Health Cover reforms, to date very few services are delivered under these arrangements. The sector perceives the current regulatory regime and funding structures act as barriers to innovative out of hospital models of care, particularly for rehabilitation and mental health services.

Reinforcing integrity in the claiming of insurance benefits

Stakeholders have acknowledged that while it is important the current regulatory framework continues to provide significant discretion for medical practitioners to provide the most appropriate care for their patient, it is essential that these arrangements include suitable integrity and accountability measures to guard against unnecessary and wasteful services.

While not a widespread problem, the incidence of disputes regarding the use of Type B and C certificates for hospital admissions has been raised by stakeholders as a concern and resulting in unnecessary administrative costs to hospitals, healthcare providers and insurers and uncertainty for patients.

[7] The Royal Australasian College of Physicians, Rehabilitation medicine physicians delivering integrated care in the community, March 2018

REFORM PROPOSALS

The Government is committed to implementing a series of reforms to improve the affordability and sustainability of the PHI sector and encourages all stakeholders to engage collaboratively in reform process.

The following proposals are considered low-cost, practical solutions which as a package contribute to Government's objectives to support the sustainability of the private health sector by allowing parties to contain costs and improve incentives for people to participate in PHI.

Consultation 1 – Increasing the age of dependents to 31, and removing the age limit for dependents with a disability, aims to encourage younger people and people with a disability to maintain PHI. Insurers will have the option of developing products appropriate for this expanded category, and insurers will be able to compete by offering a wider range of affordable policies. This reform addresses the Government's objective to improve the affordability, value, and attractiveness of PHI, particularly for younger Australians.

Consultations 2 and 3 – Expanding home and community based rehabilitation and mental health care aims to deliver on the Government's objectives to facilitate patient choice and encourage the safe and appropriate delivery of services outside of the hospital setting. These proposals provide greater scope for developing and offering out of hospital services. The development and implementation of these services is expected to take place over time through collaboration between private health insurers and healthcare providers, informed by the preferences of patients.

Consultation 4 – Applying greater rigour to Type B and C certificates for private hospital care would encourage more appropriate use of these certificates by medical practitioners and will deliver on the Government's objectives by strengthening clinical decision making, improve patient preferences and outcomes by supporting care in the appropriate setting and improve affordability by removing unnecessary costs.

CONSULTATION 1: INCREASING THE AGE OF DEPENDENTS TO ENCOURAGE YOUNGER PEOPLE AND ALSO PEOPLE WITH A DISABILITY TO MAINTAIN PRIVATE HEALTH INSURANCE

Problem Definition

Improving the membership of private health insurance, particularly amongst young people, will significantly contribute to the improved affordability of PHI and, as a consequence, the sustainability of the sector.

Currently, the maximum allowable age for dependents to be covered by PHI is 24 years. On ceasing to be a dependent, covered by their family's policy, an individual can either purchase their own policy or decide to opt-out of PHI. Purchasing a singles policy for a young adult is more expensive than when they were covered as a dependent on their family's policy.

Further, if a person has not taken out and maintained private patient hospital cover from the year they turn 31, they will pay a Lifetime Health Cover (LHC) loading on top of their private health insurance premium for every year that they are aged over 30, if they decide to take out hospital cover later in life. LHC is a Government initiative designed to encourage younger people to purchase and maintain private health insurance.

Background

On 6 October 2020, as part of the 2020-21 Budget, the Government announced it will increase the allowable age of dependents to encourage younger people and also people with a disability to maintain private health insurance from 1 April 2021[8]. It will not be mandatory for private health insurers to provide additional products with greater coverage for dependents. It will be a matter for each insurer to choose to retain the status quo or offer additional coverage.

This measure will be discussed in two parts:

- Part One: increase the maximum allowable age for dependents in PHI from the current 24 years to 31 years; and
- Part Two: remove the dependent age limit for people with a disability.

The relevant sections of the Private Health Insurance Act 2007 (the Act) and accompanying rules are at the Appendix: Legislation and Governance at the end of this document.

Current Insured Groups

Within a risk equalisation jurisdiction[9] the premium rate for a private health insurance product can only differ by product subgroups[10]. Insurers are allowed to provide cover for up to 10 different insured groups[11]. Most insurers offer coverage for the following insured groups: single - only one person; couple - 2 adults and no-one else; single parent - 2 or more people only one of whom is an adult; and family - 3 or more people only 2 of whom are adults. Table 1 contains more information about all of the insured groups. Three of the insured groups, as indicated in Table 1, are not used by insurers.

[8] Subject to the passage of legislation.
[9] The 7 risk equalisation jurisdictions are: Australian Capital Territory, Norfolk Island and New South Wales; Northern Territory; Queensland; South Australia; Tasmania; Victoria; and Western Australia and the Territory of Christmas Island and the Territory of Cocos (Keeling) Islands.
[10] Section 63-5(2A) of the *Private Health Insurance Act 2007*.
[11] Rule 5 of the *Private Health Insurance (Complying Product) Rules 2015*.

Any changes to the insured groups as a result of this measure will impact some of the data collected from private health insurers by the Australian Prudential Regulatory Authority. The single equivalent units (SEU) weighting used for risk equalisation of any new insured groups created would reflect the current status quo. For example, the current family insured group has an SEU weighting of 2, a new family insured group which includes a new type of dependent would also have a SEU weighting of 2.

Table 1: Current Insured Groups

Common name	Rule reference#	Description of type of coverage	Single equivalent unit*
single	5(1)(a)(i)	only one person	1
couple	5(1)(a)(ii)	2 adults and no-one else	2
children only	5(1)(a)(iii)	2 or more people, none of whom is an adult	2
single parent	5(1)(a)(iv)	2 or more people, only one of whom is an adult	1
single parent non student	5(1)(b)(i)	2 or more people, only one of whom is an adult, including at least one dependent child non student	1
not in use	5(1)(c)(i)	" but dependent children non students must have their own general treatment cover	1
family	5(1)(a)(v)	3 or more people, only 2 of whom are adults	2
family non student	5(1)(b)(ii)	3 or more people, only 2 of whom are adults, including at least one dependent child non student	2
not in use	5(1)(c)(ii)	" but dependent children non students must have their own general treatment cover	2
not in use	5(1)(a)(vi)	3 or more people, at least 3 of whom are adults	2

Private Health Insurance (Complying Product) Rules; * Single equivalent units (SEU) impact on premium cost, the more SEU the greater the cost.

Dependent Child Categories

The current categories and characteristics of a dependent child are listed in Table 2 below and include: infant dependent (0-17 years); student dependent (0-24 years); and non student dependent (18-24 years). Of these categories of dependent child only 'dependent child non student' is specifically defined in legislation. It was therefore necessary, for the purposes of discussion, to name the other two categories of dependent child[12]. Insurers have flexibility to define the age range and other characteristics of student and non student dependents they will cover. For example, an insurer may only cover student dependents that live with their parents up to the age of 21.

While the term child is not defined in the Act, in the context of PHI regulation it is taken to mean 'a son or daughter of any age' rather than 'a young human being below the age of puberty or below the legal age of majority'.

The existing definition of a dependent child requires a person does not have a partner. It is not proposed that this requirement will be changed.

[12] The term infant was chosen because it has the legal meaning of 'a person who has not attained legal majority'.

Table 2: Existing dependent child categories and characteristics

	Dependent Child Categories	Age Range	Partnered	Dependent Child by Insurer Rules	Applicable Insured groups (SEU)
1.	Infant dependent	0 - 17	No	not required	Single parent (1) Family (2)
2.	Student dependent	0 - 24	No	required	Single parent (1) Family (2)
3.	Non student dependent	18 - 24	No	required	Single parent non student (1) Family non student (2)

Part One: Increase the maximum allowable age for dependents in PHI from 24 years to 31 years

This part of the measure targets people aged between 25 and 31 and encourages continuity of PHI coverage to the age when LHC loadings start to apply.

While for ease of discussion the maximum age of 31 will be referred to in this paper, options for the maximum age include 31 or when LHC typically applies (1 July following a person's 31st birthday).

There are a number of options to achieve this part of the measure. To assist feedback and highlight some of the key variables three options, shown in Table 3, are set out below.

Table 3: Options for increasing the age of child dependents

Option	Dependent Child Category	Age Range	Partnered	Category defined by Insurer Rules	Applicable Insured groups (SEU)
1	infant	0 - 31	no	yes	Single parent (1) Family (2)
2	infant	0 - 17	no	no	Single parent (1) Family (2)
	student dependent	0 - 31	no	yes	Single parent (1) Family (2)
	non student dependent	18 - 31	no	yes	Single parent non student (1) Family non student (2)
3	infant	0 - 17	no	no	Single parent (1) Family (2)
	student dependent	0 - 24	no	yes	Single parent (1) Family (2)
	non student dependent	18 - 24	no	yes	Single parent non student (1) Family non student (2)
	new category of dependent	25-31	no	yes	New single parent (1) New family (2)

Increasing the allowable age of infant dependents to 31 and removing student and non student dependent categories

This option increases the allowable age for infant dependent from 0-17 to 0-31 and removes the child dependent categories of student and non student dependents. This option:

- decreases the complexity of the PHI by removing two categories of dependent child and two insured groups;
- maintains the flexibility of insurers to define a lesser age range in their rules (between 18 and 31 years); and
- only allows insurers to offer single parent and family insured groups within a product, that is the premium price cannot vary due to the age and other characteristics of the dependents.

Increasing the allowable age of student and non student dependents to 31

This option increases the allowable maximum age for the existing child dependent categories of student and non student from 24 to 31. This option:

- does not create any new insured groups;
- maintains the flexibility of insurers to define a lesser age range (between 18 and 31 years) and other requirements in their rules; and
- maintains the flexibility of insurers to offer single parent non student and family non student insured groups and to charge a higher premium within a product, than for single parent and family insured groups.

Creating a new category of dependent child and two new insured groups

This option creates a new category of dependent child. The age range for the new dependent child category would be 25-31. This allows a dependent child to progress through infant dependent, to student dependent and/or non student dependent, to the new category of child dependent. In creating a new category of dependent child it is necessary to create a new single parent insured group and a new family insured group. This option:

- increases the complexity of PHI by adding a new category of dependent and two new insured groups;
- maintains the flexibility of insurers to define a lesser age range (between 25 to 31) and other requirements in their rules; and
- allows for a three stepped pricing approach for insured groups with dependent(s), within a product.

Anticipated stakeholder impact

Private health insurers – it will not be mandatory for private health insurers to provide products in line with this proposal. Insurers may choose to retain the status quo. Insurers will investigate the cost-benefit of offering additional coverage using their own data and modelling processes. If insurers choose to offer policies in line with this proposal, it is anticipated that they will design and implement new marketing and retention strategies.

Consumers – that meet the new dependent criteria will have access to more affordable PHI products. They will need to contact their health insurer to switch to the current family policy or a new family policy that offers coverage for older dependents. This may also involve researching available offerings in the market.

Part Two: Remove the age limit for dependents with a disability

This part of the measure aims to remove the age limit for dependents with a disability so they can remain covered by their family's product.

Currently, PHI regulations do not use disability as a characteristic to define a dependent. A person with a disability is a dependent only when they are a child dependent. This limits the age a person with a disability can be a dependent up to the age of 17 (i.e. infant dependent), or 24 (i.e. student or non student dependent) if provided for in individual insurers' rules.

Type of Dependent

Three options to allow people with a disability to be covered under their parent's/s' policy beyond the current age limits for child dependents are to create a:

- new category of child dependent which is limited to people with a disability and who are over 17 years old;
- category of adult dependent which is limited to people with a disability and who are over 17 years old and create two new insured groups which contain at least one adult dependent; or
- category of adult dependent which is limited to people with a disability and who are over 31 years old and create two new insured groups which contain at least one adult dependent.

Under all these options the dependent with a disability may have a partner. However, the dependent's partner would not be covered by the dependent's family policy.

The adult dependent option allows insurers to charge a different premium price[13], within a product, due to the creation of the two new insured groups. To allow an insurer to charge a different premium price[14], within a product for the child dependent option, two additional insured groups would need to be created.

Definition of Disability

The preferred approach is for the definition of disability, and in turn eligibility, for coverage to be standardised for all private health insurers instead of being determined differently by each insurer in its rules. This is to ensure simplicity for consumers and facilitate portability when switching insurers.

For the purposes of discussion, two existing definitions of disability are below:

- a definition of disability used by the Australian Bureau of Statistics: The person is unable to do, or always needs help with any of the core activities of mobility, self-care and communication[15]
- the definition used by the National Disability Insurance Scheme: A person meets the disability requirements if:
    (a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition; and
    (b) the impairment or impairments are, or are likely to be, permanent; and
    (c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities:
        i. communication;

[13] other than for the family and single parent insured groups
[14] other than for the family and single parent insured groups
[15] 4430.0 - Disability, Ageing and Carers, Australia: Summary of Findings, 2015, Australian Bureau of Statistics

ii. social interaction;
iii. learning;
iv. mobility;
v. self-care;
vi. self-management; and

(d) the impairment or impairments affect the person's capacity for social or economic participation; and
(e) the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime.[16]

Aligning the definition, and in turn eligibility, with the National Disability Insurance Scheme would make use of an existing mechanism that is in wide use in the community and is at arms' length from insurers.

Anticipated stakeholder impact

Private Health Insurers – like part one, it will be voluntary for insurers to provide products supporting this proposal.

Consumers – families satisfying the criteria will need to investigate cover options and contact their insurer. PHI products are likely to become more affordable for families with a disabled family member.

Why this two part policy is the preferred approach

Younger people and people with a disability may pay less for private health insurance as a result of this measure because they will no longer need to purchase a separate policy. This may lead to an increase in participation of younger people in private health insurance. Also dependents will cease to be covered on the family's policy at the point where the LHC loading begins to apply, providing a clear incentive to maintain private health insurance. There may be reduced pressure on future premiums due to an increase in participation of younger people in private health insurance.

Preferred option: Regulatory Burden Estimate

It is expected that there will be negligible costs for businesses, community organisations and individuals. This assumption will be reviewed using feedback from consultation.

Alternative options that were considered

Status Quo – Do Nothing - Maintain the current age limit for dependents.

Anticipated stakeholder impact

Private health insurers – will continue to lose younger consumers from the health insurance pool, resulting in increased pressure on future premiums.

Younger consumers and consumers with a disability – may continue to find PHI unaffordable and continue to opt out of PHI.

[16] Section 24 of the *National Disability Insurance Scheme Act 2013*

QUESTIONS FOR ALL STAKEHOLDERS: DEPENDENTS

1. Should the maximum age for child dependents be 31 or when LHC typically applies (i.e. 1 July following an individual's 31st birthday)?
2. Should eligibility of a dependent continue to be limited to people without a partner?
3. Should the age ranges of different categories of child dependents be standardised for all private health insurers?
4. Should the conditions of dependence for the different categories of child dependents be standardised for all private health insurers?
5. Should the definition of 'dependent child' be simplified?
6. What purpose does the distinction between non student and student dependents serve and should this be retained?
7. Should the current 10 insured groups be rationalised by removing groups not being used by insurers?
8. What is the preferred criteria and mechanism for determining eligibility of people with a disability?
9. Should there be standardised arrangements for determining eligibility of people with a disability, or is it preferable to allow each insurer to determine its eligibility criteria?
10. Should eligibility of a dependent with a disability be limited to people without a partner?
11. What are appropriate metrics for measuring the impact of this proposal?
12. What is the regulatory burden associated with this proposal?

INSURER SPECIFIC QUESTIONS

1. In the context of this proposal, what changes do you intend to make to your current arrangements for dependents and the timing of these changes?
2. What will be your likely approach to pricing products with dependents?
3. What is the anticipated impact on your overall premium revenue if you implement this proposal?
4. What will be the expected impact on the number of people and/or policies covered if you implement this proposal?

CONSULTATION 2: EXPANDING HOME AND COMMUNITY BASED REHABILITATION CARE

Problem Definition

Rehabilitation care, specifically following an orthopaedic procedure, often occurs in hospital, when some or all of the care could, in appropriate circumstances, occur out of hospital. Care outside hospital is often preferred by patients, can deliver improved outcomes and can be more cost effective.

While there is debate about the precise numbers, it appears private patients in private hospitals receive significantly more rehabilitation in hospital than public patients in public hospitals. There also appears significant variation between jurisdictions.

Surgeons, and in some cases, general practitioners (GPs) currently have a responsibility to provide aftercare to patients in the recovery period after surgery. Aftercare includes all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.[17]

The medical practitioner determines each individual aftercare period depending on the needs of the patient as the amount and duration of aftercare following an operation may vary between patients for the same operation, as well as between different operations. However, aftercare is different to rehabilitation.

Under the Hospital Treatment Product Tiers – Gold, Silver, Bronze and Basic, rehabilitation is a clinical category, and mandatory for all tiers. The Clinical categories for PHI hospital product tier arrangements outlines the requirements for insurers to provide cover for all hospital treatments within the scope of cover for a clinical category. The scope of cover for rehabilitation is defined as '*hospital treatment for physical rehabilitation for a patient related to surgery or illness.'* For example, inpatient and admitted day patient rehabilitation, stroke recovery or cardiac rehabilitation. There are a number of MBS items used in the context of in hospital rehabilitation, most commonly consultation items used by rehabilitation physicians, but there are no specific items that are only intended for rehabilitation services.This proposal is directed at improving the process for identifying the most appropriate rehabilitation arrangements for a patient, including the most appropriate setting for those services. When privately insured services are provided in higher cost settings, the higher benefits result in increased premiums for consumers. Providing appropriate care in cost-effective settings can improve the affordability of PHI.

The Private Health Ministerial Advisory Committee's Improved Models of Care (IMOC) Working Group included a Rehabilitation Sub-Group. A key finding of the group was: *"In most cases, the regulation does not appear to present a barrier for alternatives to in hospital rehabilitation."*

The Royal Australasian College of Physicians and Australasian Faculty of Rehabilitation Medicine (AFRM) *Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals February 2019* outlines a range of elements for standards of rehabilitation service provision. These include:

[17] Medicare Benefits Schedule - Note TN.8.4, Category 3 – Therapeutic Procedures.

- "The appropriate amount of therapy that patients receive will be a minimum of three hours per day for patients who have the capacity to tolerate this amount of therapy. This should occur on a minimum of five days per week."
- ''Therapy … generally includes physiotherapy, occupational therapy, and speech and language therapy, delivered by professionally qualified and skilled staff, or by allied health assistants under the supervision of professionally qualified allied health staff."

The relevant sections of the Act and accompanying rules are at the *Appendix: Legislation and Governance* at the end of this document.

Proposed policy: Development of a rehabilitation plan that includes out of hospital care

The appropriate medical practitioner, whether it be the orthopaedic surgeon, rehabilitation physician or GP, would be responsible for developing a rehabilitation plan, which if appropriate for the patient, would include out of hospital care as part of their treatment. Depending on the circumstance, the plan may be prepared prior to surgery and revised post-surgery. Ideally, the plan would be based on published and broadly accepted clinical guidelines. It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers (such as at home health providers, community centres or hospitals). Carefully designed rehabilitation services provided in the home or community can be significantly more cost effective than similar services provided in a hospital. The payment of PHI benefits would be dependent upon an appropriate plan.

Anticipated stakeholder impact

Consumers – rehabilitation care could be provided in a more appropriate setting. Patients referred to rehabilitation services would expect a reasonable, evidence based rehabilitation service provided in line with the decisions of an appropriate medical practitioner. Many patients prefer treatments outside hospital and these services could have better patient outcomes.

Private health insurers – would have greater certainty that benefits are paid for services highly valued by consumers and optimal for health outcomes. Insurance products could be designed to offer a range of attractive privately funded rehabilitation models other than solely in hospital care.

Health providers – some hospitals and hospital based workforces may provide fewer in-hospital services and may provide more out of hospital services. Some medical practitioners may have an increased workload in determining rehabilitation arrangements as this proposal would involve the consideration of a wider range of rehabilitation options and documenting the type of rehabilitation is appropriate for each patient. Out of hospital service providers are more likely to be supported through referrals and the payment of PHI benefits as medical practitioners determine their services are the most appropriate for certain patients.

There are a growing number of providers for out of hospital care rehabilitation. These changes are expected to encourage their use and provide greater support for more services to open. A number of hospitals have indicated a willingness to provide out of hospital care.

Why this policy is the preferred approach

This reform is a step towards encouraging insurers and providers to consider an expanded range of models of care that are cost-effective and specifically designed for their patients. The rehabilitation plan would take into account the services the patient needs, the medical circumstances of the patient and other factors in determining the need for rehabilitation, and the best location for those services. The plan would ensure that the medical practitioner retains

clinical authority for rehabilitation decisions and would reinforce the need to involve the patient in decisions regarding their healthcare.

Preferred option: Regulatory Burden Estimate

Implementation would be aided by the development and endorsement of clinical guidelines, though this is unlikely to be a significant measure for relevant colleges as there are evidence based guidelines for similar purposes that could be adapted. There is a regulatory impact by requiring a rehabilitation plan for rehabilitation services. However, this should be minor as such a plan is generally considered to be good practice. Some service providers will have to renegotiate contracts with insurers. Regulatory costs will be quantified using feedback from this consultation.

Alternative Options that were considered:

Status Quo – Do Nothing

A continuation of the current situation where the majority of privately insured rehabilitation occurs in hospital.

Anticipated stakeholder impact

Consumers – receive a guarantee of rehabilitation services funded under PHI. Consumers are more likely not to be offered the option of having their care occur in the comfort of their home or in a community based care setting.

Private health insurers – will continue to pay for significantly more occasions of hospital based rehabilitation with concerns about its cost effectiveness and value to consumers.

Health providers – continue to deliver the current range of services to patients with limited scope for innovation and opportunity to enhance the service offering to patients and expand the range of services delivered by their workforce.

More flexible reimbursement for medical practitioners in rehabilitation care

Most benefits for medical services are paid for "face to face" time with patients, including consultations. Some stakeholders believe that a major impediment to moving rehabilitation out of hospital is that medical practitioners cannot easily see their patients face to face. A concern for some medical practitioners is that rehabilitation outside a hospital setting decreases their ability to quickly and easily provide MBS reimbursed fee for service treatments. There are MBS items for consulting with patients and developing medical plans, appropriate mostly for face to face consultations. There is an argument medical practitioners may perform many other services to improve the rehabilitation outcomes of patients not adequately recognised in this traditional model. There is also some evidence that allied health staff providing rehabilitation may need medical advice, such as the most appropriate change to a rehabilitation plan, without the medical practitioner needing to see that patient.

Currently, for customers with private hospital insurance cover for the medical service, the insurer must pay at least the remaining 25 per cent of the MBS fee, with 75 per cent covered by Medicare. As some medical practitioners and health providers charge more than the MBS fee for medical services received as a private patient, consumers are also incur an out of pocket cost.

Anticipated stakeholder impact

Medical practitioners – if medical practitioners are able to demonstrate the need for expanded reimbursement arrangements to facilitate out of hospital services which are clinically and cost effective, new arrangements could be considered.

Consumers – benefits would be paid to consumers as reimbursement of some costs involved.

Private health insurers – may pay these costs, or a portion of these costs, to improve the value of their product for consumers through improved models of care.

QUESTIONS FOR ALL STAKEHOLDERS: REHABILITATION SERVICES

1. Which procedures and/or MBS item numbers should have a rehabilitation plan?
2. How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?
3. What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?
4. It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?
5. What arrangements, if any, should be in place to assist medical practitioners identify appropriate home or community based rehabilitation services and oblige insurers to fund these services?
6. What transition arrangements and timeframe would be appropriate to implement this reform?
7. What are appropriate metrics for measuring the impact of this proposal?
8. What is the regulatory burden associated with this proposal?
9. Service providers: what services would you deliver under this proposal?

INSURER SPECIFIC QUESTIONS

1. In the context of this proposal, what changes do you intend to make to your current funding arrangements for home and community based rehabilitation care and in hospital care, and the timing of these changes?
2. What is the anticipated change in the number of rehabilitation services delivered in and out of hospital?
3. What is the anticipated impact on your overall premium revenue if you implement this proposal?
4. What will be the expected impact on the number of people and/or policies covered if you implement this proposal?

CONSULTATION 3: OUT OF HOSPITAL MENTAL HEALTH SERVICES

Problem Definition

The opportunity to access timely and convenient mental health treatment is important to many consumers and can make PHI attractive to consumers, including younger consumers. There are some limitations to an insurer's ability to pay benefits for non-MBS eligible mental health treatments and services delivered out of hospital. There are also limitations on the ability to pay benefits for services where there is an MBS item for this service in the out of hospital setting.

Mental illness may be chronic in nature. In such cases, PHI funding arrangements for chronic disease management programs would apply. Rule 12 of the *Private Health Insurance (Health Insurance Business) Rules 2015* permits insurers to fund non-MBS services from a specific list of allied health providers where there is a chronic disease management program in place. This list includes mental health workers and psychologists. However, these plans are usually available to prevent potential readmission to hospital; meaning that patients who have not been admitted to hospital would not access them. In addition, benefit payments are not available for a wider range of allied health practitioners.

Benefits paid for chronic disease management programs are included in private health insurance risk equalisation arrangements. This means a proportion of benefits paid for people over 55 is included in a pool paid for equally by all insurers. That proportion increases with the age of the consumer from 15 per cent for a 55 year old, to 82 per cent for someone over 85 years old. A form of risk equalisation is essential to community rating, but may decrease the benefits an individual insurer receives from funding preventative treatments.

Proposed policy part one: Benefits payable for preventative mental health treatments to all patients

Private health insurers could fund preventative mental health services from hospital treatment products to patients regardless of whether they have had a previous hospital episode or not. Insurers could decide their own rules for offering these products, which may include:

- offering preventative services to all consumers; or
- offering preventative services to consumers who are identified as meeting a set of criteria.

Proposed policy Part two: Chronic disease management programs (CDMPs) provided to a wider range of professional groups

Private health insurers could be explicitly allowed to directly fund the mental health services of a wider range of allied health professionals as part of a CDMP. These additional professionals could include nurses, peer workers, and other mental health providers.

Proposed policy Part three: Expanded payments for CDMP expenses to include indirect service delivery of low cost interventions

Private health insurers could be allowed to pay for a wider range of services. These may be limited to lower cost (per consumer covered) services. A list of services could be regulated, including subscriptions to mental health applications; or a general rule which gives insurers permission to pay for services that meet criteria. These payments, or appropriate proportions of payments could be made eligible for risk equalisation.

Anticipated stakeholder impact (for each part)

Private health insurers – would have increased flexibility to fund appropriate mental health services. Additionally, private health insurers would have increased flexibility to fund benefits for preventative mental health initiatives, which may enable consumers to avoid hospital admission. Insurers would need to negotiate arrangements for the supply of these services.

Consumers – access to additional services may improve the value proposition of PHI. Consumers may experience increased access, more appropriate and more targeted care. Consumers would have access to increased choice of mental health benefits from PHI including community support and preventative mental health care.

Why this three-part policy is preferred approach

This option would allow private health insurers to pay benefits for more mental health care services provided to patients at home or in a community setting to reduce hospital admissions, readmissions, and reduce the length of hospital stay for some patients. This would improve patient mental health, provide greater flexibility for insurers to fund more timely and efficient care, and be a more attractive insurance product.

Preferred option: Regulatory Burden Estimate

Implementation may require contracting between insurers and providers. PHI products may require restructuring. Carefully designed mental health services provided in the home or community can be significantly more cost effective than similar services provided in a hospital. Regulatory costs will be quantified using feedback from consultation.

Alternative options that were considered

Status Quo – Do Nothing

Consumers would not receive additional non-MBS out of hospital services. While the cost of these services would not increase premiums, neither would the attraction of additional mental health care attract and retain policyholders.

Anticipated stakeholder impact

Consumers – would receive a lower value insurance product which does not cover a number of non-MBS out of hospital mental health services.

Private health insurers – would have reduced capacity to innovate around low cost out of hospital non-MBS mental health service offerings to provide higher value services to their policyholders.

Greater support for non-face to face services

The provision of services in hospitals, amongst other things, enables easy access to face to face services. Supporting a greater range of services to be delivered out of the hospital, such as teleconsultations, remote monitoring or clinical advice provided from a specialist or mentor to the patient's provider may support higher quality, more timely and convenient care. Certainty regarding the funding arrangements, including private health insurers' contribution, will be critical to offering these services.

Anticipated stakeholder impact

Private health insurers – would have increased flexibility to fund appropriate mental health services.

Consumers – expansion may facilitate improved product value. Consumers may experience increased access, more appropriate and convenient care.

Mental health providers – a wider range of mental health providers would be able to access PHI benefits under contract with insurers.

QUESTIONS FOR ALL STAKEHOLDERS: MENTAL HEALTH SERVICES

1. What additional mental health services funded by insurers under this proposal would be of value to consumers?
2. Should an expanded list of allied health services available for direct PHI benefits as part of a CDMP be limited to only mental health conditions?
3. To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?
4. How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-MBS related mental health services?
5. Are there any mental health services insurers should not be permitted to fund?
6. How should the relevant patient cohort be identified as eligible for services?
7. Who should identify relevant patient cohorts and should insurers set criteria for which members would be eligible?
8. What are appropriate metrics for measuring the impact of this proposal?
9. What is the regulatory burden associated with this proposal?
10. Service providers: what services would you deliver under this proposal?

INSURER SPECIFIC QUESTIONS

1. In the context of this proposal, what changes do you intend to make to your current funding arrangements for mental health services and the timing of these changes?
2. What will be your likely approach to pricing products with expanded mental health service benefits?
3. What will be the anticipated impact on your overall premium revenue if you implement this proposal?
4. What will be the expected impact on the number of people and/or policies covered if you implement this proposal?

CONSULTATION 4: APPLYING GREATER RIGOUR TO CERTIFICATION FOR HOSPITAL ADMISSION

Problem Definition

When a patient receives hospital treatment covered by their policy, a private health insurer pays some or all of the medical practitioner's fees, theatre costs and hospital accommodation costs. For the hospital accommodation component, the more complex the procedure, the higher the benefit paid by the private health insurer.

The *Private Health Insurance (Benefit Requirements) Rules 2011* (The Rules) set out the minimum default accommodation benefits payable by private health insurers for hospital treatment, depending on the relevant MBS item for the procedure performed or service provided by the medical practitioner.

These procedures are defined in the Rules by categorising MBS items into:

- Type A procedures – performed in hospital and include part of an overnight stay (higher accommodation benefits);
- Type B procedures – performed in hospital but do not include part of an overnight stay (lower accommodation benefits); and
- Type C procedures – procedures not normally requiring hospital treatment and therefore hospital accommodation benefits are not payable (no accommodation benefits).

The Rules allow for hospital accommodation benefits to be paid for Type C procedures if certification is provided. Under Rule 7, the medical practitioner providing the professional service must certify in writing that because of the medical condition of the patient or because of the special circumstances specified, it would be contrary to accepted medical practice to provide the procedure to the patient except in a hospital. Certificates can also occur for Type B procedures to have overnight accommodation benefits.

The Department has been made aware of issues relating to the inappropriate certification of Type B and Type C procedures by a small number of providers. The main issues raised include:

- confusion and lack of awareness of certification requirements resulting in a lack of detail or incorrect information provided by hospitals and medical practitioners to insurers; and
- rejection of the medical conditions or special circumstances outlined in the certification documentation by insurers.

The Department has previously provided information about the use of Type C certificates in PHI Circular 37/7, 17 July 2017, Clarification of roles in the certification process.

Type C certificates continue to cause disputes between some insurers and private hospitals that result in payments being disputed for extended periods of time. A hospital may indicate an insurer has rejected payment. An insurer may indicate it has not rejected payment, but has received insufficient information from the hospital and/or the hospital has yet to provide additional information sought by the insurer. Insurers report that Type C certificates appear to be standardised forms with tick boxes, which insurers may interpret as a lack of specificity to the patient while providers may consider this a reasonable list of options for patients typically seen by that provider.

Disputes can also result in uncertainty for patients about whether they will be covered through PHI for a procedure.

The proposed policy outlined below is presented in three parts. Parts one, two and three in combination, will allow industry to self-regulate with minimal Government intervention.

Proposed policy part one: Establishment of a self-regulated industry panel to manage disputes

The establishment of a self-regulated industry mediation panel to review and examine possible inappropriate practice by medical practitioners when they certify that a medical procedure must be provided in hospital rather than out of hospital. The Department of Health would facilitate discussion among relevant stakeholders to establish a panel, which would then function independently without further Government support.

There is a precedent for industry self-regulation through that National Procedure Banding Committee, which is the industry steering committee represented by equal numbers of private hospitals and private health insurer representatives to oversee the management, maintenance and update of the procedure banding system. The Committee acts in an advisory capacity to hospital providers and private health insurers on all aspects of the procedure banding system.

The establishment of a similar self-regulated industry panel for hospital certification would allow independent review of Type C certifications, avoid lengthy deferral of benefit payments, and provide oversight of certification.

Anticipated stakeholder impact

Private health insurers – would have a mechanism to challenge the use of Type C certificates they perceive to be contrary to accepted medical practice.

Private hospitals – would have increased certainty about the circumstances in which they can claim hospital accommodation benefits from insurers, and thus certainty about their business model.

Medical practitioners – would have increased certainty about which circumstances are considered accepted medical practice for the provision of in hospital services and the appropriate way to certify it.

Consumers – would have reassurance the services they receive in hospital would receive insurance benefits and their levels of out of pocket cost.

Proposed policy part two: Encouraging the development of clinical guidelines for Type C procedures requiring hospitalisation by medical colleges

Medical colleges and other stakeholders could work collaboratively to create guidelines on which Type C MBS items their speciality are likely to certify and the appropriate patient circumstances where hospitalisation is required.

The current regulatory framework provides significant flexibility for medical practitioners. Guidelines would give individual medical practitioners greater confidence to treat patients in the most appropriate location. The guidelines would encourage providers to establish business models around the most appropriate practice. Insurers would have an evidence based procedure to accept, contest or request additional information around certification claims.

The additional regulatory work in developing guidelines should be more than offset by the improvements in patient care, industry certainty and the regulatory impost on medical practitioners and providers acting without industry guidance.

Anticipated stakeholder impact

Private health insurers – would have greater certainty when a medical practitioner claims to be acting in accord with accepted medical practice and any relevant questions on which location of care may depend.

Private hospitals – would have greater certainty about the provision and funding of services delivered in hospital.

Medical practitioners – would have greater certainty about accepted medical practice and therefore have greater certainty around whether benefits will be paid.

Consumers – would have reassurance the services they receive in hospital would receive insurance benefits and their levels of out of pocket cost.

Proposed policy part three: Escalation of disputes or severe breaches to the Professional Services Review for decision

The Commonwealth's Professional Services Review (PSR) was established as an Agency within the Health Portfolio to protect the integrity of Medicare and the PBS. The PSR protects patients and the community from risks associated with inappropriate practice, and protects the Commonwealth from taking on the cost of inappropriately provided medical services.

Inappropriate certification for hospital admissions imposes unnecessary costs on the health system and is not in the interests of patients and the community. Self-regulatory measures alone may not be sufficient to deal with inappropriate and egregious practices. Empowering the PSR to review alleged irregular practices associated with certification by medical practitioners and associated hospitals may provide both a significant deterrent and appropriate escalation and resolution point to resolve matters. This option will require expansion of the PSR's authority and functions, particularly in relation to investigating hospitals which have a relationship with the medical practitioner and may have significant involvement in patient care decisions.

Anticipated stakeholder impact

Private health insurers – would have an enforceable mechanism to challenge the use of Type C certificates where there appears to be a pattern of egregious behaviour that cannot be otherwise resolved.

Private hospitals and medical practitioners – will have increased certainty about the circumstances in which they can claim hospital accommodation benefits from insurers and the circumstances that are considered accepted medical practice by their peers for in hospital services. These groups would be subject to potential review by the PSR.

Why this three-part policy is preferred approach?

In combination, this option will allow industry to self-regulate with minimal Government intervention and avoid unnecessary expenditure associated with the imposition of further regulation. A self-regulated panel would enable industry to review disputes and escalate matters to a third party, the PSR, when appropriate. The preparation of guidelines covering when hospitalisation is appropriate will guide practitioner and industry behaviour often avoiding any dispute or minimising disputes to very specific areas. This option would encourage the provision of more detailed patient specific information by hospitals and medical practitioners in the first instance to avoid disputes with insurers, determine accepted medical practice where there are disputes, and provide a strong deterrent and regulatory endpoint for disputes through recourse to the PSR.

Preferred option: Regulatory Burden Estimate

The regulatory burden of the preferred package will not be significant. Given the interests of the majority of participants in the sector are to have efficient and timely self-regulatory claims and benefit payment processes, involvement of the PSR is expected to be limited to a small number of cases that would establish useful precedents and act as strong deterrents. This assessment will be reviewed using feedback from consultation.

Alternative options that were considered

Status Quo – Do Nothing

Maintain the regulatory framework for certification.

Anticipated stakeholder impact

There would continue to be disputes between private health insurers and private hospitals. In some situations, each party would have a different interpretation about the information needed to meet the requirements of the regulatory framework.

Private health insurers – private health insurers may continue to delay payment for services that are difficult to confirm were provided to patients or appear to be services that on accepted medical practice should be provided out of hospital.

Private hospitals – would continue to face delays in payments as private health insurers seek further information about the circumstances in which the services were provided, which they consider is unnecessary or unable to provide the information.

Medical practitioners – would continue to provide certifications where they consider it is appropriate, with limited recourse to information about the practices of their peers.

Consumers – would continue to face uncertainty about whether they would be covered through PHI for procedures, and if so, uncertainty about the amount of out-of-pocket cost.

Standardised form for certificates for consistency and quality of information including detailed reasons specific to the particular patient

A standardised form for certification may assist in providing sufficient and appropriate information is provided to meet the requirements of the Rules. This form could be tailored as needed for different specialties.

This could occur through regulatory change by mandating an approved form, similar to transfer certificates. The form would outline the appropriate level of detail and patient specific information to meet the definition of special circumstances for the patient to require hospital treatment.

Such a certificate may be required to be signed by the patient, to ensure they have given consent and fully understand the service to be provided. The form might also include the MBS item number for the patient to identify.

Informal stakeholder feedback indicated a form would not address the underlying issue of whether it was accepted medical practice and thus may only create an additional administrative burden.

Anticipated stakeholder impact

Private health insurers – if the form is completed properly, may be provided with more sufficient and appropriate information about the medical condition of the patient, specified special circumstances of the patient, the reasons why it would be contrary to accepted medical practice to provide the procedure to the patient except in a hospital, and confirmation of the services provided.

Providers – would have increased certainty about the information they must provide and a reduction in delays in payments from insurers if they provide the information in the specified format.

Medical practitioners – would have increased certainty about the information they must provide.

Consumers – would have increased certainty about whether they would be covered through PHI for the procedures, and if so, the amount of out-of-pocket cost.

QUESTIONS FOR ALL STAKEHOLDERS: CERTIFICATION FOR HOSPITAL ADMISSION

1. Should an industry mediation panel be established to resolve hospital certification disputes?
2. If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?
3. What parties should be involved in the development of advice on the appropriate criteria for certification?
4. Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?
5. Should there be a specified list of 'special circumstances' allowable for Type C certificates?
6. Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?
7. What is the likely impact upon premiums of this proposal?
8. What is the likely impact on the number of people and/or policies covered of this proposal?
9. What are appropriate metrics for measuring the impact of this proposal?
10. What is the regulatory burden associated with this proposal?
11. Are there any other reform options that should be considered?

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APPENDIX: LEGISLATION AND GOVERNANCE

The Private Health Insurance Act 2007 is the main law that sets out the requirements for PHI and health insurers. The Private Health Insurance Rules sit under this law. They provide more detail about different areas of PHI. PHI is administered by the Department of Health with prudential oversight provided by APRA. Consumer complaints are handled by the Private Health Insurance Ombudsman, which sits within the Office of the Commonwealth Ombudsman

REGULATIONS FOR DEPENDENTS

Key Rules	Link to Regulation
1 Dictionary ***adult*** means a person who is not a *dependent child. dependent child means a person: (a) who is: (i) aged under 18; or (ii) a dependent child under the *rules of the private health insurer that insures the person; and (b) who is not aged 25 or over; and (c) who does not have a partner. ***dependent child non student*** is defined in subsection 63-5(5). **63-5 Meaning of complying health insurance product** (1) A ***complying health insurance product*** is a *product made up of *complying health insurance policies. (2)A ***product*** is all the insurance policies issued by a private health insurer: (a) that *cover the same treatments; and (b) that provide benefits that are worked out in the same way; and (c) whose other terms and conditions are the same as each other. (2A)A ***product subgroup***, of a *product, is all the insurance policies in the product:	*Private Health Insurance Act 2007* Schedule 1- Dictionary Section 63-5(5)

(a) under which the addresses of the people insured, as known to the private health insurer, are located in the same *risk equalisation jurisdiction; and (b) under which the same kind of insured group (within the meaning of the Private Health Insurance (Complying Product) Rules) is insured. (2B)The Private Health Insurance (Complying Product) Rules may specify insured groups for the purposes of paragraph (2A)(b). An insured group may be specified by reference to any or all of the number of people in the group, the kind of people in the group, or any other matter. A group may consist of only one person. (3) Different premiums may be payable under policies in the same *product. (4) A premium payable for a policy that covers an insured group of 2 or more people that includes a *dependent child non-student may be higher than a premium payable for a policy in the same *product that covers an insured group of 2 or more people that includes one or more *dependent children but no dependent child non-student. (5) A ***dependent child non-student*** is a *dependent child who: (a) is aged between 18 and 24 (inclusive); and (b) is not receiving full-time education at a school, college or university.	

5. Insured groups (1) For the purposes of paragraph 63-5 (2A) (b) of the Act, the following insured groups are specified: (a) for policies other than a non-student policy or a policy referred to in paragraph (c), the insured groups are: (i) only one person; (ii) 2 adults (and no-one else); (iii) 2 or more people, none of whom is an adult; (iv) 2 or more people, only one of whom is an adult; (v) 3 or more people, only 2 of whom are adults; (vi) 3 or more people, at least 3 of whom are adults; (b) for policies that are a non-student policy (unless the policy is a non-student policy referred to in paragraph (c)), the insured groups are: (i) 2 or more people, only one of whom is an adult; (ii) 3 or more people, only 2 of whom are adults; (c) for non-student policies which have as conditions of the policy that the dependent child non-student is not covered for general treatment, other than hospital-substitute treatment, and must have his or her own policy with the same insurer covering general treatment (other than hospital-substitute treatment), the insured groups are: (i) 2 or more people, only one of whom is an adult; (ii) 3 or more people, only 2 of whom are adults. (2) In this rule a ***non-student policy*** is a complying health insurance policy that covers one or more dependent child non-students.	*Private Health Insurance (Complying Product) Rules 2015* 5 Insured groups
4 Single equivalent unit If a policy falls into one of the categories of policies specified in subrule (2), the single equivalent unit for the policy is the number shown next to the category in that subrule. The categories of policies, and single equivalent unit for each category, are a hospital policy under which only one person is insured—1; a hospital policy under which 2 adults are insured (and no-one else)—2; a hospital policy under which 2 or more people are insured, none of whom is an adult—1; a hospital policy under which 2 or more people are insured, only one of whom is an adult—1; a hospital policy under which 3 or more people are insured, only 2 of whom are adults—2; a hospital policy under which 3 or more people are insured, at least 3 of whom are adults—2.	*Private Health Insurance (Risk Equalisation Policy) Rules 2015* 4 Single equivalent unit

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REGULATIONS FOR REHABILITATION

Key Rules	Link to Regulation
Requirements that a policy that *covers *hospital treatment must meet: There must be a benefit for any part of *hospital treatment that is one or more of the following: (a) psychiatric care; (b) rehabilitation; (c) palliative care; if the treatment is provided in a *hospital and no *Medicare benefit is payable for that part of the treatment. The amount of the benefit must be at least the amount set out, or worked out using the method set out, in the *Private Health Insurance (Benefit Requirements) Rules* as the minimum benefit, or method for working out the minimum benefit, for that treatment.	*Private Health Insurance Act 2007* Division 72—Benefit requirements for policies that cover hospital treatment
In this Schedule, a ***rehabilitation patient*** is a patient in a hospital who is admitted for the purposes of undertaking a specific rehabilitation treatment program that is deemed by the insurer to be relevant and appropriate for the treatment of the patient's disease, injury or condition. Note: If a patient is receiving rehabilitation treatment that is not under a specific rehabilitation treatment program, the patient is taken to be in the category of 'other patient'.	*Private Health Insurance (Benefit Requirements) Rules 2011*, Schedule 1, Part 2, section 8

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REGULATIONS FOR MENTAL HEALTH

Key Rules	Link to Regulation
Chronic disease management programs (CDMPs) • Must be a health treatment, excluding some natural therapies • There is a written treatment plan managed by the patient's primary carer (e.g. GP) for a chronic disease • Benefits payable for non-MBS items and are provided by a list of allied health services	*Private Health Insurance (Health Insurance Business) Rules 2015* Part 3, 12 (page 12)
Allied health service means a health service provided by any of the following allied health professionals who were eligible, at the time the service was provided, to claim a Medicare rebate for a service of that type: • an Aboriginal health worker; • audiologist; • chiropodist; • chiropractor; • diabetes educator; • dietician; • exercise physiologist; • mental health worker; • occupational therapist; Authorised Version F2019C00531 registered 09/07/2019 • Part 3 Hospital and general treatment • Private Health Insurance (Health Insurance Business) Rules 2018 14 • Compilation No. 3 Compilation date: 1/7/19 Registered: 9/7/19 • osteopath; • physiotherapist; • podiatrist; • psychologist; • (n) speech pathologist.	*Private Health Insurance (Health Insurance Business) Rules 2015* Section 12 (page 13)

Clinical category Hospital psychiatric services	**Scope of Cover** Hospital treatment for the treatment and care of patients with psychiatric, mental, addiction or behavioural disorders. For example: psychoses such as schizophrenia, mood disorders such as depression, eating disorders and addiction therapy.	**Treatments that must be covered (MBS Items)** 170 171 172 289 297 320 322 324 326 328 342 344 346 348 350 352 364 366 367 369 370 855 857 858 861 864 866 2713 2721 2723 2725 2727 6018 6019 6023 6024 6025 6026 6028 6029 6031 6032 6034 6035 6037 6038 6042 14224 80005 80015 80020 80101 80105 80115 80120 80130 80140 80145 80155 80165 80170 90250 90251 90252 90253 90254 90255 90256 90257 90264 90265 90272 90274 90276 90278	*Private Health Insurance (Complying Product) Rules 2015* Schedule 5 (page 42)
Psychiatric treatment means hospital treatment, or hospital-substitute treatment, that is psychiatric care. ***specialist psychiatric treatment*** means psychiatric treatment provided to a person who is: (a) an admitted patient of a hospital; and (b) under the care of an addiction medicine specialist or consult psychiatrist.			*Private Health Insurance (Complying Product) Rules 2015* 4 Definitions (page 3)
For the purposes of paragraph 63-10(g) of the Act, an insurance policy must not reduce a benefit for psychiatric treatment provided to a person if the reduction is because of: (a) the number of psychiatric treatments, for which there is or has been an entitlement to a benefit under any policy, provided to the person during a period; or (b) the number of a particular kind of such psychiatric treatments provided to the person during a period.			*Private Health Insurance (Complying Product) Rules 2015* 5A Psychiatric Treatment -Limitations (page 5)
In this Schedule, a ***psychiatric patient*** is a patient in a hospital who is admitted for the purposes of undertaking a specific psychiatric treatment program that is deemed by the insurer to be relevant and appropriate for the treatment of the patient's disease, injury or condition. Note: If a patient is receiving psychiatric treatment that is not under a specific psychiatric treatment program, the patient is taken to be in the category of 'other patient'.			Private Health Insurance (Benefit Requirements) Rules 2011 7 Psychiatric patient (page 14)

REGULATIONS FOR TYPE C CERTIFICATES

Key Rules	Link to Regulation
if agreed by stakeholders (especially as stipulated in existing legislation; the Australian Medical Association), the Professional Services Review legislation could be amended, most likely including a separate, stand-alone Schedule, given the unrelated nature of this compliance work to its existing work.	*Part VAA of the* Health Insurance Act 1973*;* and Health Insurance (Professional Services Review Scheme) Regulations 2019
Schedule 1, Part 3 – Section 10 Certified Type B procedures and certified overnight Type C procedures **10. Certified Type B procedures** (1) Minimum benefits for overnight accommodation are payable for patients receiving a Type B procedure only if certification under subclause (2) is provided. (2) Certification must be provided as follows: (a) the practitioner providing the Type B procedure; or (b) a professional employed by a hospital who is involved in the provision of the procedure provided by that hospital, must certify in writing that: (c) because of the medical condition of the patient specified in the certificate; or (d) because of the special circumstances specified in the certificate, it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital for a period that includes part of an overnight stay. **11. Certified overnight Type C procedures** (1) Minimum benefits for overnight accommodation are payable for patients receiving a certified Type C procedure only if: (a) certification has first been provided for the Type C procedure in accordance with clause 7 of Schedule 3; and (b) certification under subclause (2) is also provided. (2) Certification must be provided as follows the practitioner providing the certified Type C procedure must certify in writing that: (a) because of the medical condition of the patient specified in the certificate; or (b) because of the special circumstances specified in the certificate, it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital for a period that includes part of an overnight stay. Schedule 3, Part 2, Type B procedures, section 3	*Private Health Insurance (Benefit Requirements) Rules 2011* Schedule 1, Part 3 – Section 10 Certified Type B procedures and certified overnight Type C procedures Schedule 3, Part 2, Type B procedures, section 3 to 6 Schedule 3 Part 2, Section 7 Certified Type C procedures Schedule 3 Part 3, Section 8 Type C procedures

. Interpretation A Type B procedure is a procedure specified as a Band 1, 2, 3 and 4 as described in this Part. Note: These procedures normally require hospital treatment that does not include part of an overnight stay. Schedule 3 Part 2, Section 7 7 Certified Type C procedure Note: Type C procedures are procedures that do not normally require hospital treatment. (1) Benefits for day-only accommodation are payable for patients receiving a Type C procedure only if certification under subclause (2) is provided. (2) Certification must be provided as follows, the medical practitioner providing the professional service must certify in writing that: (a) because of the medical condition of the patient specified in the certificate; or (b) because of the special circumstances specified in the certificate, it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital for a period that does not include part of an overnight stay. Schedule 3 Part 3 Type C procedures 8. Interpretation A Type C procedure is a procedure specified in this clause by reference to MBS items. Note: These procedures normally do not require hospital treatment.	