Reporting Standard HRS 605.0

Private Health Insurance Reform Data Collection

Objective of this reporting standard

This Reporting Standard sets out requirements for the provision of information to APRA relating to a private health insurer's implementation of private health insurance reforms.

It includes *Reporting Form HRF 605.0 Private Health Insurance Reform Data Collection* (HRF 605.0) and associated specific instructions.

Authority

1. This Reporting Standard is made under section 13 of the *Financial Sector (Collection of Data) Act 2001*.

Purpose

2. Information collected under this Reporting Standard is for the purpose of enabling APRA to assist the Department of Health in performing its functions. This information may also be used by APRA for prudential and publication purposes.

Application

3. This Reporting Standard applies to all private health insurers.

Commencement

4. This Reporting Standard applies to reporting periods ending on or after ~~1 April~~ 31 March 202~~1~~0.

Information required

5. A private health insurer must provide APRA with the information required by HRF 605.0 in respect of each reporting period.

6. The information required by this Reporting Standard, as set out in HRF 605.0, must be provided for each health benefits fund of the private health insurer.

Form and method of submission

7. The information required by this Reporting Standard must be given to APRA in an electronic method (i.e. a web-based solution) available on APRA's website, or by a method notified by APRA, in writing, prior to submission.

Reporting periods and due dates

8. Subject to paragraph 10 of this Reporting Standard, a private health insurer to which this Reporting Standard applies must provide the information required by this Reporting Standard in respect of each calendar quarter (i.e. the periods ending 30 September, 31 December, 31 March and 30 June).

9. Subject to paragraph 11 of this Reporting Standard, the information required by this Reporting Standard must be provided to APRA within 28 calendar days after the end of the reporting period to which the information relates.

10. APRA may change the reporting periods, or specified reporting periods, for a particular private health insurer, to require it to provide the information required by this Reporting Standard more frequently, or less frequently, having regard to:

    (a) the particular circumstances of the private health insurer;

    (b) the extent to which the information is required for the purposes of prudential supervision of the private health insurer; and

    (c) the requirements of the Department of Health.

11. APRA may, in writing, grant a private health insurer an extension of a due date in which case the new due date will be the date specified in the notice of extension.

    Note: For the avoidance of doubt, if the due date for a particular reporting period falls on a day other than a usual business day, a private health insurer is nonetheless required to submit the information required no later than the due date.

Quality control

12. All information provided by a private health insurer under this Reporting Standard must be the product of systems, processes and controls that have been reviewed and tested by the appointed auditor of the private health insurer as set out in *Prudential Standard HPS 310 Audit and Related Matters*. Relevant standards and guidance statements issued by the Auditing and Assurance Standards Board provide information on the scope and nature of the review and testing required from external auditors. This review and testing must be done on an annual basis or more frequently if necessary to enable the external auditor to form an opinion on the accuracy and reliability of the information provided by a private health insurer under this Reporting Standard.

13. All information provided by a private health insurer under this Reporting Standard must be subject to systems, processes and controls developed by the private health insurer for the internal review and authorisation of that information. These systems, processes and controls are to assure the completeness and reliability of the information provided.

Authorisation

14. A person who submits the information required under this Reporting Standard must be authorised, in writing, by an officer of the private health insurer.

Minor alterations to forms and instructions

15. APRA may make minor variations to:

    (a) a form that is part of this Reporting Standard, and the instructions to such a form, to correct technical, programming or logical errors, inconsistencies or anomalies; or

    (b) the instructions to a form, to clarify the application to the form,

    without changing any substantive requirement in the form or instructions.

16. If APRA makes such a variation, it must notify each private health insurer that is required to report under this Reporting Standard.

Interpretation

17. In this Reporting Standard:

    APRA means the Australian Prudential Regulation Authority established under the *Australian Prudential Regulation Authority Act 1998.*

    due date means the relevant due date under paragraph 9 or, if applicable, the date on a notice of extension given under paragraph 11 of this Reporting Standard.

    officer has the meaning in the *Private Health Insurance (Prudential Supervision) Act 2015.*

    private health insurer has the meaning in the *Private Health Insurance (Prudential Supervision) Act 2015*.

    reporting period means a period mentioned in paragraph 8 or, if applicable, a period specified under paragraph 10 of this Reporting Standard.

18. Unless the contrary intention appears, a reference to an Act, Prudential Standard or Reporting Standard is a reference to the instrument as in force or existing from time to time.

19. Where this Reporting Standard provides for APRA to exercise a power or discretion, this power or discretion is to be exercised in writing.

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1. Movements of insured persons

Number of persons movements (1)	Sex (2)	Age (3)	Policy or person movement reason (4)	Private hospital insurance product tiers (5)	Policy treatment type (6)	Geography (7)	Psychiatric care waiting period exemption (8)
	Female		Discontinued	Basic	General treatment only	NSW	Used
	Male		New	Bronze	Hospital and general treatment combined	VIC	Not used
	Other		Transfer from another fund	Silver	Hospital treatment only	QLD	Not applicable
	Not stated or inadequately described		Transfer from another policy	Gold		SA	
			Transfer from another state	Not applicable		WA	
			Transfer to another policy			TAS	
			Transfer to another state			ACT	
						NT	

2. Insured Persons

Number of persons (1)	Sex (2)	Age (3)	Private hospital insurance product tiers (4)	Policy cover type (5)	Policy treatment type (6)	Excess ~~and co-payment~~ amount (7)	Age-based discount amount (8)	Geography (9)	Psychiatric care waiting period exemption (10)
	Female		Basic	Single	General treatment only		N/A	NSW	Used
	Male		Bronze	Family	Hospital and general treatment combined		2%	VIC	Not used
	Other		Silver	Single parent	Hospital treatment only		4%	QLD	Not applicable
	Not stated or inadequately described		Gold	Couple			6%	SA	
			Not applicable	Two plus persons, no adults			8%	WA	
				Three plus adults			10%	TAS	
								ACT	
								NT	

3. Policies

Number of policies (1)	Private hospital insurance product tiers (2)	Policy cover type (3)	Policy treatment type (4)	Excess ~~and co-payment~~ amount (5)	Geography (6)
	Basic	Single	General treatment only		NSW
	Bronze	Family	Hospital and general treatment combined		VIC
	Silver	Single parent	Hospital treatment only		QLD
	Gold	Couple			SA
	Not applicable	Two plus persons, no adults			WA
		Three plus adults			TAS
					ACT
					NT

4. Hospital ~~S~~services, benefits, fees charged, treatment days and episodes

Number of services (1)	Benefits paid (2)	Fees charged (3)	Treatment days (4)	Episodes (5)	Age (6)	Hospital and hospital substitute treatment types (7)	Psychiatric care (8)	Geography ~~(9)~~(8)	Admission ~~(10)~~(9)	Hospital type ~~(11)~~(10)	Private hospital type ~~(12)~~(11)	Length of treatment ~~(13)~~(12)	Psychiatric care waiting period exemption (1~~4~~3)
						Medical services~~ other than psychiatric services~~	Yes	NSW	First admission	Public hospital	Day	Overnight	Used
						Other~~Medical services - psychiatric services~~	No	VIC	Subsequent admission	Private hospital	Not day	Day	Not used
						Prosthetics~~Other~~		QLD	Not applicable	Hospital substitute	Not applicable	Not applicable	Not applicable
						Hospital cover - travel and accommodation~~Prosthetics~~		SA		Not hospital			
						Not applicable~~Hospital cover - travel and accommodation~~		WA					
						~~Not applicable~~		TAS					
								ACT					
								NT					

Reporting Form HRF 605.0

Private Health Insurance Reform Data Collection

Instruction Guide

This instruction guide is designed to assist in the completion of *Reporting Form HRF 605.0 Private Health Insurance Reform Data Collection* (HRF 605.0). This form collects information on a private health insurer's (PHI's) implementation of the Government's private health insurance reforms announced in October 2017.

General directions and notes

Reporting entity

HRF 605.0 must be completed by all PHIs for each health benefits fund of the PHI.

Reporting period

This form is to be completed in respect of each calendar quarter (i.e. the periods ending 30 September, 31 December, 31 March and 30 June).

Unit of measurement

This form must be completed in whole Australian dollars (no decimal place).

Definitions

Terms highlighted in ***bold italics*** indicate that the definition is provided in these instructions.

Age	Means the age of the insured person at the date of treatment, or where no treatment is provided, the age of the person at the end of the ***reporting period***. Where an insured person changes age during an episode: a) the episode is to be reported in the age that the episode was finalised; b) the days and benefits are to be reported for the age in which they were incurred (e.g. a 20 day episode with an accommodation cost of $200 per day, where the insured person turned 50 on day 4, is reported as: 1 episode under 50-54, 3 days under 45-49 and 17 days under 50-54, $600 under 45-49 and $3,400 under 50-54) Note: apportionment of benefits by the number of days in each age only relates to the case where the treatment covers more than one age, for example an invoice is received for accommodation for a period where the person had a number of days in one age group and a number of days in another age group. In the case where individual treatments are paid during a single episode where the person moves from one age group to another the benefits paid for those treatments should be reported against the age of the person as at the date of the treatment. Do not sum all benefits paid over an episode spanning two age groups and then apportion them over the age groups; and c) services are reported under the age at the date of treatment.
Basic (private hospital insurance product tier)	Means a health insurance policy (policy) that: a) covers ***hospital treatment***; b) covers at least the treatments in all of the clinical categories indicated for a basic policy in Schedule 4 of the *Private Health Insurance (Complying Product) Rules 2015*; and c) is not a ***Gold***, ***Silver***, or ***Bronze*** policy.
Bronze (private hospital insurance product tier)	Means a policy that: a) covers ***hospital treatment***; b) covers at least the treatments in all of the clinical categories indicated for a bronze policy in Schedule 4 of the *Private Health Insurance (Complying Product) Rules 2015*; and c) is not a ***Gold*** or ***Silver*** policy.
Couple (policy cover type)	Means a policy under which two adults are insured (and no-one else).
Day (length of treatment)	Means the treatment is one day only.
Day (private hospital type)	Means a private hospital that is not licensed or otherwise permitted to provide treatment that includes part of an overnight stay at a hospital.

Discontinued (policy or person movement)	Means policies and insured persons leaving the health fund. Represents the balancing item for the aggregate fund coverage from one quarter to the next. This includes: • deaths (decrease in insured persons, not necessarily policies); • suspended policies, where they are not included in the coverage count for risk equalisation purposes; and • policies with ***hospital and general treatment combined*** that drop ***hospital treatment*** cover or drop ***general treatment*** cover.
Excess ~~***and co-payments***~~	Means an amount of money a policy holder agrees to pay before private health insurance benefits are payable. ~~A ***co-payment*** could apply every time a person insured under the policy goes to hospital in a year, or a~~An ***excess*** may be capped at a total amount for the year. ~~The terms ***excess*** and ***co-payments*** are sometimes referred to as front-end deductibles and are similar in meaning.~~ For taxation purposes those taxpayers who would be subject to the Medicare Levy Surcharge are exempted if they have a ***hospital treatment*** policy with an ***excess*** no greater than $750 for a policy covering a single person or an ***excess*** no greater than $1,500 for a policy covering more than one person. ***Excess*** ~~***and co-payments***~~ policies includes all policy holders who contribute to ***hospital treatment*** policies under which an agreed, ***excess*** amount is paid by the policy holder for ***hospital treatment*** and/***or general treatment*** services, reducing the benefit otherwise payable in exchange for lower premium costs. ***Excess*** (front-end deductible) An ***excess*** is an amount of money a policy holder agrees to pay for a hospital stay before health fund benefits are payable. For example, if a policy has an ***excess*** of $200, the insured person will be required to pay the first $200 of the hospital costs if they go to hospital as a private patient. An ***excess*** could apply every time the insured person goes to hospital in a year, or it may be capped at a total amount that will be paid in each year. ~~***Co-payment***~~ ~~With a ***co-payment***, a policy holder agrees to pay an agreed amount each time a service is provided. For example, a policy may have a ***co-payment*** clause that requires payment for the first $50 for each day's hospital accommodation. If the policy has such a ***co-payment*** and they were in hospital for 5 days, they would have to pay $250 ($50 x 5).The total amount of ***co-payment*** that can be paid in a year is often limited to a set maximum amount.~~
Family (policy cover type)	Means a policy under which three or more people are insured, only two of whom are adults.
Female (sex)	Means persons who have female or predominantly feminine biological characteristics, or female sex assigned at birth.

General treatment	Has the meaning given by the *Private Health Insurance Act 2007* (PHI Act).
General treatment only (policy treatment type)	Means a policy that does not cover hospital or hospital-substitute treatments.
Gold (private hospital insurance product tier)	Means a policy that: a) covers ***hospital treatment***; and b) covers the treatments in all of the clinical categories indicated for a gold policy in Schedule 4 of the *Private Health Insurance (Complying Product) Rules 2015*.
Hospital cover - travel and accommodation (hospital and hospital substitute treatment type)	Means accommodation expenses for a parent/partner to accompany a patient who is an in-patient of a public or private hospital. It is also in relation to travel costs where a patient receives treatment at a hospital more than a specified distance from a patient's home and in circumstances where the patient chooses not to be an in-patient. These benefits should be recorded against the ***age*** of the patient, not the parent/partner.
Hospital and general treatment combined (policy treatment type)	Means a policy that covers ***hospital*** and ***general treatments***.
Hospital treatment	Has the meaning given by the PHI Act.
Hospital treatment only (policy treatment type)	Means a policy that covers only ***hospital treatments***.
Male (sex)	Means persons who have male or predominantly masculine biological characteristics, or male sex assigned at birth.
Medical services (hospital and hospital substitute treatment type)	Means benefits paid for ~~both~~ ***medical services*** ~~***– other than psychiatric services***~~ ~~and~~ ~~***medical services – psychiatric services***~~ provided as part of ***hospital treatment*** or hospital-substitute treatment if a Medicare benefit is payable for the service.

~~***Medical services - other than psychiatric services (hospital and hospital substitute treatment type)***~~	~~Means benefits paid for ***medical services***, excluding ***medical services - psychiatric services,*** provided as part of ***hospital treatment*** or hospital substitute treatment if a Medicare benefit is payable for the service.~~
~~***Medical services - psychiatric services (hospital and hospital substitute treatment type)***~~	~~Means ***medical services*** for the treatment and care of patients with psychiatric, mental, addiction or behavioural disorders, provided as part of hospital or hospital substitute treatment if a Medicare benefit is payable for the service.~~
New (policy or person movement)	Means the policy or insured person has joined but has not transferred from another fund.
Not applicable (private hospital type)	Means a public hospital or a hospital substitute facility.
Not day (private hospital type)	Means a private hospital that is licensed or otherwise permitted to provide treatment that includes part of an overnight stay at a hospital.
Not stated or inadequately described (sex)	Means the sex of a person is not stated or is inadequately described.
Number of persons movements	Means the number of insured persons movements. Includes changes in the ***policy cover type***.
Other (hospital and hospital substitute treatment type)	Means a treatment other than ***medical services***, ***prosthetics***, or ***hospital cover - travel and accommodation***.
Other (sex)	Means persons who have mixed or non-binary biological characteristics (if known), or a non-binary sex assigned at birth.
Overnight (length of treatment)	Means the treatment involves more than one day.
Policy	Means a health insurance policy.

Policy treatment type	Means the type of treatment covered by a policy. The ***policy treatment types*** are: • ***general treatment only***; • ***hospital and general treatment combined***; and • ***hospital treatment only***.
Policy cover type	Means the type and number of people covered by a policy. The ***policy cover types*** are: • ***single***; • ***family***; • ***single parent***; • ***couple***; • ***two plus persons, no adults***; and • ***three plus adults***.
Private hospital insurance product tiers	Means the private hospital insurance product tiers as listed in Schedule 4 of the *Private Health Insurance (Complying Product) Rules 2015*. The ***private hospital insurance product tiers*** are: • ***Basic***; • ***Bronze***; • ***Silver***; and • ***Gold***.
Prosthetics (hospital and hospital substitute treatment type)	Means a treatment related to prostheses of the kinds listed in the relevant legislation.
Silver (private hospital insurance product tier)	Means a policy that: a) covers ***hospital treatment***; b) covers at least the treatments in all of the clinical categories indicated for a silver policy in Schedule 4 of the *Private Health Insurance (Complying Product) Rules 2015*; and c) is not a ***Gold*** policy.
Sex	Means the distinction between ***male***, ***female***, and others who do not have biological characteristics typically associated with either the male or female sex.
Single (policy cover type)	Means a policy under which only one person is insured.
Single parent (policy cover type)	Means a policy under which two or more people are insured, only one of whom is an adult.

Three plus adults (policy cover type)	Means a policy under which three or more people are insured, at least three of whom are adults.
Transfer from another fund (policy or person movement)	Means the policy or insured person has transferred from another fund but is not joining as a new fund member to private health insurance.
Transfer from another policy (policy or person movement)	Means the policy or insured person has transferred from another ***policy treatment type*** with the same insurer. ***Transfer from another policy*** refers to transfers between the treatment types of ***hospital treatment only***, ***hospital treatment and general treatment combined*** and ***general treatment only***. Note that a change in the ***policy cover type*** (e.g. ***single*** to ***couple***) does not constitute a change in treatment policy.
Transfer from another state (policy or person movement)	Means the policy or insured person has transferred from another state within the same fund.
Transfer to another policy (policy or person movement)	Means the policy or insured person has transferred to another ***policy treatment type*** with the same insurer. ***Transfer to another policy*** refers to transfers between the treatment types of ***hospital treatment only***, ***hospital treatment and general treatment combined*** and ***general treatment only***. Note that a change in the ***policy cover type*** (e.g. ***single*** to ***couple***) does not constitute a change in treatment policy.
Transfer to another state (policy or person movement)	Means the policy or insured person has transferred to another state within the same fund.
Two plus persons, no adults (policy cover type)	Means a policy under which two or more people are insured, none of whom is an adult.
Waiting period	The ***waiting period*** for a benefit under an insurance policy is the period: 1. starting at the time the person becomes insured under the policy; and 2. ending at the time specified in policy; during which the person is not entitled to the benefit.

Psychiatric care definitions

Benefits paid	The ***benefits paid*** under a psychiatric care ***waiting period*** exemption means the total eligible benefit***s*** paid by the PHI for an episode that occurred during the two months waived period for the quarter.
First admission	To be considered a ***first admission*** with psychiatric care ***waiting period*** exemption, a ***first admission*** must have occurred within the first two months of the upgrade and the person must have decided to use the once-off exemption for the admission.
Subsequent admission	Means subsequent admissions to a hospital for the same condition as the initial admission. To be considered a ***subsequent admission*** with ***waiting period*** exemption, a ***subsequent admission*** must have occurred within the waived period.
Used	A psychiatric care ***waiting period*** exemption has been ***used*** if: • a person transfers to a policy which provides higher benefits for psychiatric treatment than the benefit for psychiatric treatment under the old policy; • the person makes a claim under the new policy for psychiatric treatment within the first two months following the product upgrade; and • the person decides to utilise the once-off exemption and receive higher benefits for that admission. A psychiatric care ***waiting period*** exemption has not been ***used*** if all of the above do not apply, or if the ***waiting period*** exemption is not applicable.

Specific instructions

Table 1: Movements of insured persons

Column 1	Report the ***number of persons movements*** during the ***reporting period***.
Column 2	Report according to the ***sex*** of the insured persons (see item 1 for further details).
Column 3	Report the ***age*** of the insured persons.
Column 4	Report the policy or person movement reason (see item 1 for further details).
Column 5	Report the ***private hospital insurance product tier*** (see item 1 for further details).
Column 6	Report the ***policy treatment type*** (see item 1 for further details).
Column 7	Report the relevant geographical area (see item 1 for further details).
Column 8	Report whether a psychiatric care ***waiting period*** exemption has been ***used*** (see item 1 for further details).

Item 1	Report the ***number of persons movements*** during the ***reporting period*** for each unique combination of: • ***sex***; • ***age***; • policy or person movement reason; • ***private hospital insurance product tier***; • ***policy treatment type***; • geographical area; and • psychiatric care ***waiting period*** exemption. The ***sex*** options are: • ***female***; • ***male***; • ***other***; and • ***not stated or inadequately described***. The policy or person movement reasons are: • ***discontinued***; • ***new***; • ***transfer from another fund***; • ***transfer from another policy***; • ***transfer from another state***; • ***transfer to another policy***; and • ***transfer to another state***.

	The ***private hospital insurance product tiers*** are: • ***Basic***; • ***Bronze***; • ***Silver***; • ***Gold***; and • not applicable. The ***policy treatment types*** are: • ***general treatment only***; • ***hospital and general treatment combined***; and • ***hospital treatment only***. The geographical areas are: • New South Wales (NSW); • Victoria (VIC); • Queensland (QLD); • South Australia (SA); • Western Australia (WA); • Tasmania (TAS); • Australian Capital Territory (ACT); and • Northern Territory (NT). The psychiatric care ***waiting period*** exemption options are: • ***used***; • not ***used***; and • not applicable.

Table 2: Insured persons

Column 1	Report the number of insured persons as at the last day of the ***reporting period***.
Column 2	Report according to the ***sex*** of the insured persons (see item 2 for further details).
Column 3	Report the ***age*** of the insured persons.
Column 4	Report the ***private hospital insurance product tier*** (see item 2 for further details).
Column 5	Report the ***policy cover type*** (see item 2 for further details).
Column 6	Report the ***policy treatment type*** (see item 2 for further details).
Column 7	Report the value of the ***excess ~~and co-payment~~*** amount~~s~~.
Column 8	Report the age-based discount amount as a percentage (see item 2 for further details).
Column 9	Report the relevant geographical area (see item 2 for further details).
Column 10	Report whether a psychiatric care ***waiting period*** exemption has been ***used*** (see item 2 for futher details).

Item 2	Report the number of insured persons as at the last day of the ***reporting period*** for each unique combination of: • ***sex***; • ***age***; • ***private hospital insurance product tier***; • ***policy cover type***; • ***policy treatment type***; • ***excess ~~and co-payment~~*** amount~~s~~; • age-based discount amount; • geograph~~y~~ical area; and • psychiatric care ***waiting period*** exemption. The ***sex*** options are: • ***female***; • ***male***; • ***other***; and • ***not stated or inadequately described***. The ***private hospital insurance product tiers*** are: • ***Basic***; • ***Bronze***; • ***Silver***;

	• ***Gold***; and • not applicable. The ***policy cover types*** are: • ***single***; • ***family***; • ***single parent***; • ***couple***; • ***two plus persons, no adults***; and • ***three plus adults***. The ***policy treatment types*** are: • ***general treatment only***; • ***hospital and general treatment combined***; and • ***hospital treatment only***. The age-based discount amount options are: • N/A; • 2%; • 4%; • 6%; • 8%; and • 10%. The geographical areas are: • New South Wales (NSW); • Victoria (VIC); • Queensland (QLD); • South Australia (SA); • Western Australia (WA); • Tasmania (TAS); • Australian Capital Territory (ACT); and • Northern Territory (NT). The psychiatric care ***waiting period*** exemption options are: • ***used***; • not ***used***; and • not applicable.

Table 3: Policies

Column 1	Report the number of policies as at the last day of the ***reporting period***.
Column 2	Report the private hospital insurance product tier (see item 3 for further details).
Column 3	Report the ***policy cover type*** (see item 3 for further details).
Column 4	Report the ***policy treatment type*** (see item 3 for further details).
Column 5	Report the value of the ***excess*** ~~***and co-payment***~~ amount~~s~~.
Column 6	Report the relevant geographical area (see item 3 for further details).

Item 3	Report the number of policies as at the last day of the ***reporting period*** for each unique combination of: • ***private hospital insurance product tier***; • ***policy cover type***; • ***policy treatment type***; • ***excess*** ~~***and co-payment***~~ amount~~s~~; and • geographical area~~y~~. The ***private hospital insurance product tiers*** are: • ***Basic***; • ***Bronze***; • ***Silver***; • ***Gold***; and • not applicable. The ***policy cover types*** are: • ***single***; • ***family***; • ***single parent***; • ***couple***; • ***two plus persons, no adults***; and • ***three plus adults***. The ***policy treatment types*** are: • ***general treatment only***; • ***hospital and general treatment combined***; and • ***hospital treatment only***. The geographical areas are: • New South Wales (NSW); • Victoria (VIC); • Queensland (QLD); • South Australia (SA); • Western Australia (WA);

	• Tasmania (TAS); • Australian Capital Territory (ACT); and • Northern Territory (NT).

Table 4: Hospital s~~S~~ervices, benefits, fees charged, treatment days and episodes

Column 1	Report the number of services during the ***reporting period***.
Column 2	Report the value of benefits paid during the ***reporting period***.
Column 3	Report the value of fees charged during the ***reporting period***.
Column 4	Report the number of treatment days during the ***reporting period***.
Column 5	Report the number of episodes during the ***reporting period***.
Column 6	Report the ***age*** of the insured persons.
Column 7	Report the hospital and hospital substitute treatment type (see item 4 for further details).
Column 8	Report whether psychiatric care has been provided (see item 4 for further details).~~Report the relevant geographical area (see item 4 for further details).~~
Column 9	Report the relevant geographical area (see item 4 for further details).~~Report the admission category (see item 4 for further details).~~
Column 10	Report the admission category (see item 4 for further details).~~Report the hospital type (see item 4 for further details).~~
Column 11	Report the hospital type (see item 4 for further details).~~Report the private hospital type (see item 4 for further details).~~
Column 12	Report the private hospital type (see item 4 for further details).~~Report the length of treatment (see item 4 for further details).~~
Column 13	Report the length of treatment (see item 4 for further details).~~Report whether a psychiatric care ***waiting period*** exemption has been ***used*** (see item 4 for further details).~~
Column 14	Report whether a psychiatric care ***waiting period*** exemption has been ***used*** (see item 4 for further details).

Item 4	Report the number of services, benefits paid, fees charged, number of treatment days and number of episodes during the ***reporting period*** for each unique combination of: • ***age***; • hospital and hospital substitute treatment type;

	• psychiatric care; • geograph~~y~~ical area; • admission type; • hospital type; • private hospital type; • length of treatment; and • psychiatric care ***waiting period*** exemption. The hospital and hospital substitute treatment types are: • ~~***medical services - other than psychiatric services;***~~ • ~~***medical services - psychiatric services***~~; • ***other***; • ***prosthetics***; • ***hospital cover - travel and accommodation***; and • not applicable. The psychiatric care o~~p~~etions are: • yes; and • no. The geographical areas are: • New South Wales (NSW); • Victoria (VIC); • Queensland (QLD); • South Australia (SA); • Western Australia (WA); • Tasmania (TAS); • Australian Capital Territory (ACT); and • Northern Territory (NT). The admission categories are: • ***first admission***; • ***subsequent admission***; and • not applicable. The hospital types are: • public hospital; • private hospital; ~~and~~ • hospital substitute; and • not hospital. The private hospital types are: • ***day***; • ***not day***; and • ***not applicable***. The length of treatment options are: • ***overnight***; • ***day***; and

	• not applicable. The psychiatric care ***waiting period*** exemption options are: • ***used***; • not ***used***; and • not applicable.