Private Health Insurance (Risk Equalisation Administration) Rules 2015

I, [insert name of delegate], delegate of APRA make these Rules under subsection 172(1) of the *Private Health Insurance (Prudential Supervision) Act 2015*.

Dated: xx June 2015

[To be signed]

Contents

Part 1 – Preliminary

1. Name of Rules

These Rules are the *Private Health Insurance (Risk Equalisation Administration) Rules 2015*.

2. Commencement

These Rules commence:

(a) if the Rules are registered before the day on which the Act commences – at the same time as the Act commences; or

(b) if the Rules are registered on or after the day on which the Act commences – on the day after the Rules are registered.

3. Interpretation

Note: Terms used in these Rules have the same meaning as in the Act – see section 13 of the *Legislative Instruments Act 2003*. These terms include:

APRA
complying health insurance policy
Cover
health benefits fund
officer
policy holder
private health insurer
risk equalisation jurisdiction

(1) In these Rules:

Act means the *Private Health Insurance Act 2007*.

Adult is as defined in the Act.

Business Rules means the *Private Health Insurance (Health Insurance Business) Rules 2013* made under the Act.

chronic disease management program or ***CDMP***:

(a) has the same meaning as in the Business Rules; and

(b) for hospital treatment, includes a program similar to a chronic disease management program as referred to in the definition of 'eligible benefit' in the Risk Equalisation Policy Rules.

fund means a health benefits fund.

general treatment is as defined in the PHI Act.

hospital cover is as defined in the PHI Act.

hospital-substitute treatment is as defined in the PHI Act.

hospital treatment is as defined in the PHI Act.

medicare benefit is as defined in the PHI Act.

insured person, in relation to a policy, means a person covered by the policy.

insurer means a private health insurer.

PHIAC means the Private Health Insurance Administration Council established under the *National Health Act 1953*.

policy means a complying health insurance policy.

quarter means a period of 3 months ending on 31 March, 30 June, 30 September or 31 December in a year.

Quarterly return means a return required under the *Financial Sector (Collection of Data) Act 2001* relating to risk equalisation information.

Risk Equalisation Policy Rules means the *Private Health Insurance (Risk Equalisation Policy) Rules 2007* made under the Act.

(2) In these Rules, a ***category of policy*** is to be identified as follows:

(a) for a policy under which only one person is insured – as 'single';

(b) for a policy under which 2 adults are insured (and no-one else) – as 'couple';

(c) for a policy under which 2 or more people are insured, none of whom is an adult – as '2 + persons, no adults';

(d) a policy under which 2 or more people are insured, only one of whom is an adult – as 'single parent';

(e) a policy under which 3 or more people are insured, only 2 of whom are adults – as 'family';

(f) a policy under which 3 or more adults are insured – as '3 + adults'.

(3) In these Rules, the following terms relevant to the high cost claimants pool have the same meaning as in the Risk Equalisation Policy Rules:

age based pool (ABP)
designated threshold
high cost claimants pool (HCCP)
gross benefit

Part 2 – Requirement for records to be kept

4. General records

For each fund conducted by an insurer, the insurer must keep records that contain the following details about each policy of the fund:

(a) the name, date of birth, age and principal place of residence of each person covered by the policy; and

(b) which of the following the policy covers:

(i) hospital treatment;

(ii) hospital-substitute treatment;

(iii) chronic disease management programs;

(iv) ambulance service;

(v) other general treatment; and

(c) whether the policy includes any excesses or co-payments payable; and

(d) the category of policy by reference to the number of adults and dependent children covered; and

Note: Subrule 3 (2) deals with the identification of ‘categories of policies’.

(e) for each benefit that is paid to or on behalf of an insured person:

(i) the name of the insured person to whom the benefit relates; and

(ii) the medical or health speciality for which the benefit was paid; and

(iii) whether the benefit was paid for:

(A) hospital treatment; or

(B) hospital-substitute treatment; or

(C) chronic disease management program treatment; or

(D) ambulance services; or

(E) other general treatment; and

(iv) if the treatment was provided in accordance with a chronic disease management program, the type of disease for which the program was provided and whether the treatment was provided as hospital treatment or general treatment; and

(v) the gross benefits paid; and

(vi) the date of treatment; and

(vii) the date of payment.

5. High cost claimants pool records

(1) This rule applies if the insurer includes in a quarterly return a gross benefit for the high cost claimants pool.

(2) In addition to the information to be kept in accordance with rule 4, the insurer must keep a record that contains the following information in respect of the insured person to whom the gross benefit relates:

(a) the name and age of the person; and

(b) the dates of the treatment; and

(c) the gross benefits paid; and

(d) the dates of payment; and

(e) the amount of gross benefit included in the age based pool; and

(f) the amount of gross benefit included in the high cost claimants pool; and

(g) the amount of gross benefits paid for any of the preceding 3 quarters (after 1 April 2007).

Part 3 – Transition

6. Transition

Any approval, determination or other exercise of discretion by PHIAC under Part 1 or Part 2 of the *Private Health Insurance (Risk Equalisation Administration) Rules 2007* as they existed prior to 1 July 2015 will continue to have effect following 1 July 2015 as though exercised pursuant to a corresponding power under these Rules.