Reporting Form HRF 601.0 series
Statistical Data by State

Explanatory notes

The HRF 601.0 series includes *Form HRF 601.0 Statistical Data – Cover Page* (HRF 601.0) and *Form HRF 601.1 Statistical Data - by* State (HRF 601.1) that collect statistical data on a State or Territory basis. The HRF 601.0 series must be completed for each health benefits fund of the private health insurer.

Disclaimer

In the case of any contradiction between these reporting instructions and the relevant legislation, the legislation should be deemed to be the correct interpretation.

Definitions

Definitions for terms used in these reporting instructions can be found in the Attachment to these reporting instructions.

'The Act' refers the *Private Health Insurance (Prudential Supervision) Act 2015.*

Units of measurement

All financial values, quantities and percentages must be reported to no more than two decimal places.

Financial values must be reported in Australian dollars.

Instructions for specific items

HRF 601.0

On HRF 601.0 include the name of the private health insurer, name of health benefits fund, the quarter for which the HRF 601.0 series is being submitted and contact details for the Officer that APRA should contact if APRA wishes to query any details of the return.

If the return is being resubmitted, indicate that it is a resubmission and list the state/s for which the return is being resubmitted. A hard copy including HRF 601.0 is required for the resubmitted states. An explanatory statement should be provided showing the reason for resubmission. The declaration must be signed by an Officer of the health insurer. Officer is as defined in *Prudential Standard HPS 001 Definitions*. By signing the declaration the Officer is making a legal statement that the information provided is true and correct.

Note that APRA processing requires the entire file with all states to be submitted. If there are no persons resident in a state, a nil return for that state is required.

Templates are issued with a default setting of zero (0) in all fields, this is a nil return. Funds must fill in all (white) fields before submitting to APRA. Some fields are automatically calculated, these fields are in grey.

HRF 601.1

Report details for: date quarter ending, name of health benefits fund and details for contact Officer. These details may be linked to HRF 601.0.

The FundID is a number allocated by APRA to uniquely identify health insurers. This number can be obtained from APRA, but health insurers are not expected to enter a number in this field.

The reporting forms are preset for each Risk Equalisation Jurisdiction (state). Policies and insured persons are reported in the state of their principal place of residence as at the end of the quarter. State amounts as zero if there are no such persons in the jurisdiction. If a benefit is paid[1] to or on behalf of an insured person during a quarter and the person changes his or her principal place of residence to another risk equalisation jurisdiction during the quarter, the person's principal place of residence is the place at which the person resides at the end of the quarter.

In the case of a policy group with two or more policy holders whose addresses are not in the same risk equalisation jurisdiction the health insurer has 20 days, from the date of notification, to make a determination as to which state/s to report the policy holders and persons. Otherwise the policy holders and dependants should be reported in the state which corresponds to the address of the first person named in the policy records of the health insurer.

Dependants should be reported in the same state as the policy holder. In the case of a dependant residing in a different state to the policy holder/s they should be reported in the state of the first named policy holder unless the health insurer has made a different determination as described in the preceding paragraph.

Insured adults are referred to in the Act as policy holders. Health insurers will be required to keep details of each policy holder.

Part 1 Polices and Insured Persons

The data in this part is to be reported as at the end of the quarter being reported.

1. In sections 1 to 7, defined below, report the number of policies and the number of insured persons that are covered by the type of product. These are entered by type of cover and type of policy. It is not expected that health insurers will have to identify policy holders with more than one type of policy. New joins should be reported when the policy commences. This is the date from which the health insurer provides cover, which is not necessarily the same as when the policy becomes financial or when it is entered into the health insurer's system.

    (a) Type of cover includes single, family, single parent, couple, 2+ persons no adults, 3+ adults. These should be reported on the HRF 601.1 according to the Rules:

[1] A benefit is regarded as being paid during a quarter in which both the benefit is recorded and liability for it is accepted.

Description of insured groups from the Rules	Mapped to HRF 601.1
(a) for policies other than a non-student policy (see the Rules for the definition of a non-student policy) or a policy referred to in paragraph (c), the insured groups are:	
(i) only one person;	Single
(ii) 2 adults (and no-one else);	Couple
(iii) 2 or more people, none of whom is an adult;	2+ persons no adults
(iv) 2 or more people, only one of whom is an adult;	Single parent
(v) 3 or more people, only 2 of whom are adults;	Family
(vi) 3 or more people, at least 3 of whom are adults;	3+ no 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;	Single parent
(ii) 3 or more people, only 2 of whom are adults;	Family
(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;	Single parent
(ii) 3 or more people, only 2 of whom are adults.	Family

(b) Type of policy includes excess and co-payments, no excess and no co-payments, exclusionary and non-exclusionary.

(c) In sections 4 to 7 membership is reported under type of cover only.

2. Sections

Section 1. Total Hospital Treatment (includes Hospital Treatment Only and Hospital Treatment and General Treatment Combined)

Section 2. Hospital Treatment Only (do not include Hospital-linked ambulance cover)

Section 3. Hospital Treatment and General Treatment Combined

Section 4. General Treatment Ambulance Only

Section 5. Total General Treatment Only (includes General Treatment Ambulance Only)

Section 6. General Treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment

Section 7. Total General Treatment (includes Total General Treatment Only and Hospital Treatment and General Treatment Combined)

3. General guidance

(a) Section 1 is the sum of Section 2 and Section 3.

(b) Hospital-substitute treatment is classed as general treatment but it must be part of a hospital treatment policy. Hospital-substitute treatment is reported under Section 3.

(c) Products that offer CDMP do not require a hospital treatment policy. A policy covering CDMP and no hospital treatment is reported under Section 5.

(d) When the status of dependants (e.g. a student dependant) is temporarily unknown some restricted access funds do not take these dependants off the parents policy, although they do not provide cover for them. Due to the restricted nature of the fund, the person may not be able to re-join the fund on a single policy under the rules of the fund if they were taken off the policy. In this case it would not be appropriate to change the policy from Family to 3+Adults.

(e) General Treatment Ambulance Only is a subset of Total General Treatment Only. Total General Treatment is the sum of Hospital Treatment and General Treatment Combined and Total General Treatment Only.

(f) General Treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment is a subset of Total General Treatment. Total persons in this section should equal the number of persons reported in Part 6. Hospital-linked Ambulance Treatment is defined as ambulance cover provided together with hospital treatment cover without any other general treatment (other than Hospital Substitute or CDMP). The policies and persons in this section are the total policies and persons with ancillary/extras cover and includes Ambulance Only. The policies may cover other general treatment such as CDMP and Hospital-Substitute and may cover hospital treatment but **must** also cover ancillary/extras.

4. Changes during the quarter

This section reports changes and movement in the membership over the quarter. There should be no negative numbers reported under this section.

(a) For start of quarter policies and insured persons report the number of policies and the number of insured persons that are covered by the type of product, in each of the treatment categories: "Hospital Treatment Only", "Hospital Treatment and General Treatment" and "General Treatment Only". The start of quarter should be the same as that reported in the previous quarter for end of quarter policies and persons.

(b) New polices does not include policies being transferred from another fund. In the case of persons transferring from another fund to an existing policy they are reported as new persons only, not new policies. New policies/persons includes reinstated policies and persons, where those policies and person were counted as discontinued in a previous quarter due to their suspension (note that if a policy/person is both suspended and reinstated within the quarter to which this return relates they should not be counted as discontinued or reinstated). Where there are births or deaths within an existing policy this will constitute new persons or discontinued persons but not new or discontinued policies.

(c) When a policy is *Transferring to another state* and at the same time *transferring to another policy*. It will be double counted if entered under both headings. It is to be entered:

i) under the policy they are leaving report under *Transferring to another state*; or

ii) under the policy they are entering report under *Transferring from another policy.*

(d) Transfers to and from another policy refers to transfers between the treatment types of “Hospital Treatment Only”, “Hospital Treatment and General Treatment” and “General Treatment Only”. Note that a change in the type of cover (e.g. single to couple) does not constitute a change in treatment policy for the purposes of this section.

(e) With the introduction of Lifetime Health Cover and the need for tracking the transferring members to maintain their certified age, health funds are required to report whether a member is joining from another health fund. This should enable funds to split out new membership into new members in the industry as opposed to new members from other funds.

(f) Discontinued represents the balancing item for the aggregate fund policies/persons from one quarter to the next. Included in this category is: deaths (decrease in persons, not necessarily policies) and suspended policies/persons, where they are not included in the count for Risk Equalisation purposes.

(g) End of quarter policies/persons should equal corresponding totals as reported in Part 1 of the return.

Part 2 Total Benefits Paid for Hospital Treatment and General Treatment

The data in this part is to be reported as cumulative totals over the quarter being reported.

5. Report the number of episodes, days and total benefits paid in each hospital category.

6. Report number of and total benefits paid for medical services, prostheses items and CDMP.

7. Report total ineligible hospital benefits. The category Ineligible Benefits is for hospital benefits that are not eligible for Risk Equalisation. They are not reported in any other part of the form.

8. General guidance

(a) Episodes are reported in each category (place where the treatment was provided) in the quarter in which the treatment ceased, this excludes incomplete episodes, *see (d)*. Episodes are to be determined as:

i) hospital treatment provided at a hospital, the period between the insured person's admission to the hospital and discharge from that hospital, including leave periods, as one episode

For:

ii) hospital-substitute treatment, and

iii) hospital treatment that is provided, or arranged, with the direct involvement of a hospital, the continuous period between the commencement and cessation of the treatment as one episode.

(b) Days must reflect the total days related to each episode, including days when no fund benefit is paid.

(c) Leave days from a hospital stay are excluded from reporting days.

(d) Where an episode has not been completed in a quarter (an incomplete episode) but a benefit has been paid in relation to the treatment because of an interim billing arrangement the following applies:

i) the episode should not be reported in the current quarter, the episode is counted as one episode in the quarter in which it is completed.

ii) days and benefits are reported in the quarter they are paid.

It is recognised that this will result in some mismatching of data within quarters.

(e) Days for Day hospital, day only public hospitals, day only private hospitals and day only for hospital-substitute should equal Day only episodes in the respective categories.

(f) Medical benefits should equal the sum of medical benefits reported in Parts 3 and 4, and should equal the total fund benefits reported in Part 11 - Total Hospital Treatment Medical Service Statistics.

(g) Prostheses benefits should equal the sum of prostheses benefits reported in Parts 3 and 4.

(h) Hospital benefits, hospital-substitute benefits and Nursing Home Type Patients benefits reported in this part exclude Medical and Prostheses Benefits.

9. High Cost Claimants Pool (HCCP)

Report HCCP benefits in the state in which the person is resident at the end of the quarter, and associated HCCP data in the same state.

(a) Report the number of insured persons with a HCCP claim in the current quarter.

(b) Report the total (gross) benefit paid for HCCP claimants for the current and the preceding three quarters for the insured persons with a HCCP claim in the current quarter.

(c) Report the net benefit paid for HCCP claimants for the current and the preceding three quarters after Age Based Pooling (ABP) has been applied for the insured persons with a HCCP claim in the current quarter.

(d) Report the net benefit paid above the threshold for HCCP claimants for the current and the preceding three quarters after ABP has been applied. This amount will include any amounts already included in the HCCP.

(e) Report the total benefit to be included in HCCP for the current quarter after ABP has been applied, which is the amount from (d) less any amounts already reported in the HRF 601.1 for inclusion in the HCCP.

(f) Threshold in relation to the high cost claimant's pool means the designated threshold. The threshold is $50,000.

The amount to be notionally allocated to the HCCP is to be calculated in accordance with the formula m(R-T) - H, where:

(a) **m** is 82 per cent

(b) **R** is the total gross benefit for the current and the preceding three quarters less the amount notionally allocated to the ABP in the current and preceding three quarters

(c) **T** is the designated threshold
(d) **H** is the sum of the amounts notionally allocated to the HCCP in the preceding three quarters.

Subject to a maximum of 82 per cent of gross benefits being included in Risk Equalisation when summing the ABP and HCCP components.

(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2007)

It is not intended that the HCCP calculation will deduct amounts or result in negative amounts, for example as a result of an adjustment, through literal application of the above formula in cases where no benefits have been previously allocated to the HCCP for the claimant.

The amount to be notionally allocated to the HCCP is calculated as:

$$Min\left\{Max\left[0,\left[\left\langle\sum_{i=q}^{q-3}C_i(1-p)\right\rangle-T\right]m-\sum_{i=q-1}^{q-3}HCCP_i\right],C(m-p)\right\}$$

where:

C = gross benefits in the quarter for the claimant
m = 82 per cent
p = percent of gross benefits to be allocated to ABP in the quarter, where p is dependent on the age of the claimant
q = current quarter
T = HCCP Threshold = $50,000
C_i(1-p) = the residual after age based pooling (ABP)
C (m-p) = the maximum allowable proportion of gross benefits to be allocated to the HCCP after ABP.

The above formula sums up the residual benefits after ABP for the current and preceding three quarters, takes out the threshold ($50,000), multiplies the result by 82 per cent and from this amount subtracts the sum of benefits that were already included in the HCCP in the preceding three quarters. If this calculation is less than zero (could be as a result of reversal) the formula will return zero and if it is not zero will return the calculated benefit. Further, this calculated benefit undergoes another test to ensure that no more than 82 per cent of the gross benefits are included in Risk Equalisation. The amount to be notionally allocated to the HCCP is taken to be the minimum of the previously calculated benefit or the sum of maximum allowable proportion of gross benefits to be allocated in the HCCP after ABP for the current and the preceding three quarters.

Circular 08/04 of 25 January 2008 provides detailed information to assist health insurers complete the high cost claimants section of the HRF 601.1, with a spreadsheet example attached to the circular.

Parts 3 to 6 Collections by Type of Product and Age Category

The data in these parts is to be reported by age and gender:

- for insured persons in the age cohort that they are in at the end of the quarter; and
- for all other headings as cumulative totals over the quarter being reported.

10. Part 3 and 4 - “Other HT Benefits” and “Other H-ST Benefits” refers to benefits paid for hospital treatment or hospital-substitute treatment respectively and includes hospital charges such as accommodation and theatre fees. Do not include Medical, Prostheses and Ineligible Benefits under this heading.

11. Part 3 and 4 - Total benefits for Part 3 are the sum of “Other HT Benefits” + “Medical benefits” + “Prostheses benefits”. Total benefits for Part 4 are the sum of “Other H-ST Benefits” + “Medical benefits” + “Prostheses benefits”. Benefits should be reported:

    (a) in the quarter in which they are paid;

    (b) against the age of the person as at the date of treatment; and

    (c) reversals in benefits should be reported against the age of the person as at the date of treatment if possible, but may be reported against the age of the person as at the time of the reversal.

12. Part 3, 4 and 6 - Services and Episodes are reported under the age at the date of treatment.

13. Part 3 and 4 - Requirements for reporting episodes, days and benefits are the same as reporting requirements in Part 2 (*see Part 2 general guidance*).

14. All parts - Where an insured person changes age cohort during an episode:

    (a) the episode is to be reported in the age cohort that the episode was finalised;

    (b) the days and benefits are to be reported for the age cohort 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 four, 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 that apportionment of benefits by the number of days in each age cohort only relates to the case where the treatment covers more than one age cohort, 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 age of the treatment. (It is not the intent that health insurers should 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.

15. Part 3 and 4 - Medical benefits are reported as benefits paid under all policies only if a Medicare benefit is payable for the service.

16. Part 3 and 4 - Prostheses benefits are reported separately.

17. Part 3 and 4 - Report the fees charged equal to the total amount the patient would have to pay to the provider/s in the absence of any private health insurance, inclusive of hospital, medical and prostheses fees. The amount entered here must exclude the Medicare benefit. The difference between fees charged and benefits paid should be the amount that the patient has to pay (out of pocket payment). If the total fee is not known, e.g. where the provider

discounts fee for early payment, enter the invoiced amount. Fees excluding Medicare benefit should be greater than or equal to the sum of other benefits, medical benefits and prostheses benefits.

18. Part 5 - Chronic Disease Management Program (see the section on *Guidance for insurers for eligible CDMP benefits for risk equalisation* in these reporting instructions for further information on CDMPs).

    (a) Programs are reported in the quarter in which the program commenced, in the age category of the participant at the beginning of the program. Programs that run continuously for more than one year are classed as complete at the end of one calendar year after initial commencement. They are reported as a commencing program in the next quarter in which benefits are paid for the program.

        i) The commencement date of the program, and thus the first quarter in which the program is deemed to have commenced, should be taken as the date on which benefits were first paid for under the program. The commencement date of the program may be hard to determine due to the different ways benefits can be paid, as well as delays in this information being relayed to health insurers. The first quarter that benefits are paid for a CDMP should be taken as the quarter in which the program commences.

        ii) Benefits and fees charged are reported in the quarter in which they are paid in the age category of the participant. Where an insured person changes age cohort during a program, services are reported against the age of the participant at the date benefits were paid for the treatment.

        iii) The number of programs does not refer to the particular programs offered by the health insurer, but refers to the number of persons participating in a program.

        iv) If a person participates in more than one program, each program they participate in is counted separately.

        v) Where an insured person changes age cohort during a program, services are reported against the age of the participant at the date of treatment.

    (b) Eligible benefits are reported as the benefit paid for any of the following components of general and/or hospital treatment provided as part of a chronic disease management program:

        i) the planning and coordination services described in paragraphs (b) and (c) of the definition of chronic disease management program in the *Private Health Insurance (Health Insurance Business) Rules 2013*; and

        ii) allied health services, as defined in the *Private Health Insurance (Health Insurance Business) Rules 2013*, which are provided as part of the chronic disease management program.

    (c) Ineligible benefits report all benefits paid that are not eligible benefits.

    (d) Fees excluding Medicare benefits: as health insurers are precluded from paying benefits for out-of-hospital services for which a Medicare benefit

is payable (except in the circumstances outlined in Rule 10 of the *Private Health Insurance (Health Insurance Business) Rules 2013* this should be interpreted as “fees” only as no Medicare benefits are payable.

19. Part 6 - General Treatment excluding Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment

    (a) Report the number of persons by age with General Treatment coverage excluding those with Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment. These persons are those with ancillary or extras cover.

    (b) Report the number of General Treatment services, benefits and fees excluding Hospital-Substitute and CDMP.

    (c) Services, benefits and fees reported in Part 6 should reconcile with services, benefits and fees reported in Part 9.

        i) Services, benefits and fees should include those for ambulance even where these are on behalf of a person with Hospital-linked Ambulance Treatment and the person is not included in this part.

        ii) Note that health management programs are reported in each quarter that benefits are paid for the program. The commencement date of the program, and thus the first quarter in which the program is deemed to have commenced, should be taken as the date on which benefits were first paid for under the program. Note that the program would be deemed to be ceased in the case where the participant leaves the program (for example, by choice or other reason such as death). Note that number of programs does not refer to the particular programs offered by the health insurer, but refers to the number of persons participating in a program. If a member participates in more than one program, each program they participate in is counted.

        iii) Programs that are similar to, but do not satisfy the criteria for, CDMPs should be reported under Part 9 General Treatment.

Part 7 Total Hospital Treatment Policies by Type of Cover

The intention of Part 7 is to determine contributors by their level of excess.

The data in this part is to be reported as at the end of the quarter being reported.

20. Excess relates to the maximum excess that could be payable in any one year. (An excess may also be referred to as a Front End Deductible.) For consistency in reporting from health insurers it should be noted that the $500/$1,000 relates to the Australian Taxation cut-off, above which there is a Medicare Levy surcharge.

21. Full Cover records the coverage that has no restriction on benefits paid after 12 months of the policy commencing. This could be regarded as a 100 per cent product, with no exclusions. Coverage with a co-payment (and no other restriction) is not defined as having reduced cover. Where a fixed percentage is paid (e.g. 85 per cent benefit of contract fee) the 15 per cent payable by the policy holder should be regarded as a moiety or co-payment, and not reduced cover. Products that pay, for example, 100 per cent on contracted hospitals but a fixed benefit on non-contract hospitals should be regarded as full cover. A Full Cover product may have policies reported at all levels of co-payments.

22. Reduced cover refers to policies that restrict benefits paid after 12 months of membership, e.g. provides some form of default benefits for a period of time. This includes excesses, both day and amount. Products that have a fixed benefit regardless of the fees charged are included in the reduced benefits category. A product that pays fixed benefits will have a nil Excess/Co-payment unless there is an additional moiety attached to the product.

23. Some Lifetime Exclusions refers to polices that provide no benefits for certain occurrences for the life of the membership. (Note that an exclusionary product excludes certain treatments in all settings, for example hip replacement, but does not include the exclusion of services not covered by Medicare, for example cosmetic surgery).

24. Excess relate to the maximum Excess that could be payable in any one year.

25. In the category >$500/$1,000 the intention is for funds to report those policies that are subject to the Medicare Levy Surcharge due to the size of their Excess. Policies that are not subject to the Medicare Levy Surcharge should not be reported on this line.

Part 7 General Treatment claims processing for the state

(excluding Hospital-Substitute Treatment and CDMP)

26. General Treatment claims processing (excluding Hospital-Substitute Treatment and CDMP) - Report the percentage of General Treatment claims processed within five working days. General Treatment claims processing cannot be greater than 100 per cent.

Part 7 National retention index – Hospital Treatment policy holders

27. Retention Index – Hospital Treatment policy holders. The retention index is designed to provide a performance indicator by showing the percentage of policies that have remained active hospital policies of the same fund for two years or more, over all states.

28. If a policy holder changes their coverage from hospital treatment, or hospital treatment and general treatment combined, to general treatment only then they would not be regarded as having retained their hospital treatment policy. A policy which is suspended at the quarter end date is not included in the totals in HRF 601.1. They should not be included in the retention index. If they are re-instated they would then be included as if there had been no lapse in their coverage. The retention index is calculated based on policies as: [Policies at end of reporting quarter less policies joining over the previous eight quarters including the reporting quarter] divided by [policies at end of the quarter nine quarters previously]. The retention index should be reported correct to two decimal points.

    Example

    The reporting/current quarter is June 2007

    As at 30 June 2005 there were 100 policies over all states for the fund

    The number of new polices joining after 30 June 2005 is 20

    The number of policies over all states for the fund as at 30 June 2007 is 110

    The retention index is [110 – 20]/100 = 90.00%

As the retention index will provide an indicator for the total fund membership the calculation is not specific to individual states. The number reported should be the same for each state and territory reported in HRF 601.1 for a fund in a quarter.

The Retention index cannot be greater than 100 per cent.

Part 8 Benefits Paid for Chronic Disease Management Programs

(NOTE see the section on *Guidance for insurers for eligible CDMP benefits for risk equalisation* in these reporting instructions for further information on CDMPs)

The data in this part is to be reported as cumulative totals over the quarter being reported and include both eligible and ineligible benefits. The data reported in this part should only be for programs that satisfy the criteria for CDMP as defined under the Act and associated Rules.

29. Benefits Paid for CDMPs - report the number of services, benefits and fees charged in each of the categories in the quarter they are paid. Note that only Planning, Coordination and Allied Health Services components are eligible for Risk Equalisation so it will be necessary for health insurers to identify “Other” goods and services involved in the delivery of the program.

30. Benefits Paid by Program Type - report the number of programs, benefits and fees charged for each of the program types.

31. Programs are reported in the quarter that they commenced. The commencement date of the program may be hard to determine due to the different ways benefits can be paid, as well as delays in this information being provided to health insurers. The first quarter that benefits are paid for a CDMP should be taken as the quarter in which the program commences.

    Programs that run continuously for more than one year are classed as completed at the end of the calendar year from commencement and a new program is reported as commencing in the next quarter that benefits are paid for the program.

    (a) The commencement date of the program, and thus the first quarter in which the program is deemed to have commenced, should be taken as the date on which benefits were first paid for under the program.

    (b) The number of programs does not refer to the particular programs offered by the health insurer, but refers to the number of persons participating in a program.

    (c) If a member participates in more than one program, each program they participate in is counted.

32. Benefits and fees charged are recorded in the quarter in which they are paid.

Part 9 Benefits Paid for General Treatment

The data in this part is to be reported as cumulative totals over the quarter being reported.

33. Report the number of services, benefits paid and fees charged for General Treatment excluding Hospital-Substitute Treatment and CDMP.

34. Include, for example, payments for ambulance, ex-gratia payments and payment for travel in this part under General Treatment. Do not include them as "ineligible hospital benefits".

    (a) Services benefits and fees on behalf of a person with Hospital-linked Ambulance Treatment should be included in this part, even in those cases where the person is not included in Part 6.

    (b) Note that health management programs are reported in each quarter that benefits are paid for the program. The commencement date of the program, and thus the first quarter in which the program is deemed to have commenced, should be taken as the date on which benefits were first paid for under the program. Note that the program would be deemed to be ceased in the case where the participant leaves the program (for example, by choice or other reason such as death). Note that number of programs does not refer to the particular programs offered by the health insurer, but refers to the number of persons participating in a program. If a member participates in more than one program, each program they participate in is counted.

    (c) Programs that are similar to, but do not satisfy the criteria for, CDMPs should be reported under Part 9 General Treatment.

Part 10 Lifetime Health Cover

The data in this part is to be reported as at the end of the quarter being reported.

35. Report the number of adults with hospital cover by gender at their Lifetime Health Cover certified age at entry.

36. The fields in the columns heading "loading removed" should all have zero reported until 2010. Loadings removed in any other circumstances should not be reported. Report the number of adults with hospital cover by gender at their certified age at entry that have the loading removed. The loading is removed if the adult has held cover:

    (a) for a continuous period of 10 years; or

    (b) for a period of 10 years that has been interrupted only by permitted days without hospital cover or periods during which the adult was taken to have had hospital cover otherwise than because of paragraph 34-15(2)(a) of the *Private Health Insurance Act 2007* (none of which count towards the 10 years).

37. Instructions for completing the HRF 601.1 when and adult has their loading removed.

    When an adult paying a loading has had ten continuous years paying the loading and the loading has been removed, that person should be shown as having the loading removed in the quarter in which that occurs. In subsequent quarters, they should be reported as having a certified age at entry of 30.

    The following describes the HRF 601.1 reporting requirements with an example using a fictitious female who is initially paying a loading of 4 per cent.

    - Initially the health insurer has no adults who have paid the LHC loading for ten years. All adult persons are reported in the first two columns,

signifying they are paying a loading or their certified age at entry is 30 and they do not incur a loading.

Part 10 Lifetime Health Cover					
Lifetime Health Cover					
Number of Adults with Hospital Cover					
Certified age at entry	Male	Female	Male LHC loading removed	Female LHC loading removed	LHC loading%
30	100	100	0	0	0%
31	0	0	0	0	2%
32	0	1	0	0	4%
33	0	0	0	0	6%

- In the quarter in which the loading is removed, the person should be reported in the column under "Male LHC loading removed" or "Female LHC loading removed" in the row corresponding to the loading they were previously paying. They should not also be reported in the row corresponding to a certified age at entry of 30 with no loading. There should be no double counting.

  Example: Assume a female has paid the LHC loading at 4% for ten years, so the loading is removed. In the first quarter that the loading is removed the adult female is reported in the column "Female LHC removed" in the **same** row (4%).

Certified age at entry	Male	Female	Male LHC loading removed	Female LHC loading removed	LHC loading%
30	100	100	0	0	0%
31	0	0	0	0	2%
32	0	**0**	0	**1**	4%
33	0	0	0	0	6%

- In the quarter **after** the quarter in which the loading is removed the person should be reported in one of the first two columns, "Male" or "Female", in the certified age at entry of 30 row.

  Example: In subsequent quarters the adult female is reported in the second column at a certified age at entry of 30, with no loading.

Certified age at entry	Male	Female	Male LHC loading removed	Female LHC loading removed	LHC loading%
30	100	**101**	0	0	0%
31	0	0	0	0	2%
32	0	0	0	0	4%
33	0	0	0	0	6%

- If a person ceases to have hospital cover after their loading is removed, for more than the prescribed "Permitted days without hospital cover" as defined in section 34-20 of the *Private Health Insurance Act 2007*, and they take up hospital insurance again they should be reported in one of the first two columns "Male" or "Female", in the certified age at entry row corresponding to the loading they incur on rejoining.

Example: The same female then drops private health insurance for a number of years including a period that is not permitted days without hospital cover. The adult female later takes up private health insurance again. Due to the period without private health insurance she may have to pay, for example, a 10% loading. She is reported in column 2 at a certified age of entry of 35 (refer to LHC legislation for calculation of the appropriate loading).

Certified age at entry	Male	Female	Male LHC loading removed	Female LHC loading removed	LHC loading%
30	100	100	0	0	0%
31	0	0	0	0	2%
32	0	0	0	0	4%
33	0	1	0	0	6%

Part 11 Total Hospital Treatment Medical Services Statistics

The data in this part is to be reported as cumulative totals over the quarter being reported. Report Medical Services Statistics for hospital-substitute treatment where the treatment includes professional services for which a Medicare benefit is payable as outlined in *Private Health Insurance (Health Insurance Business) Rules 2013*.

38. Medical service statistics are collected in this section under the different headings of No Gap agreement, Known Gap agreement and No agreement and for different ranges of amount charged in relation to the MBS fee:

    (a) amount charged <= MBS Fee

    (b) amount charged >MBS to 125% MBS Fee

    (c) amount charged >125% to 150% MBS Fee

    (d) amount charged >150% to 200% MBS Fee

    (e) amount charged >200% MBS Fee.

39. For the amount charged report the amount accepted in full payment (if known), or the invoice amount.

40. Report the amount that Medicare pays for the procedure. The Medicare benefit for in-hospital procedures and hospital-substitute treatment is set at 75 per cent of the schedule fee.

41. Report the amount that the fund pays for the service.

42. The term Agreement is applicable where the health insurer has an agreement with a provider in regard to no gap or known gap.

    It is also applicable to the situation where a medical service has no gap or known gap as stipulated under the conditions of the fund's policy. For example, where the conditions of the policy state there will be no gap where the provider charges no more than a certain amount, regardless of whether there is a formal agreement with the provider.

Guidance for insurers for eligible CDMP benefits for risk equalisation

43. Guidance for insurers completing HRF 601.1 to report eligible benefits for risk equalisation.

The purpose of this section is to provide guidance to health insurers about when and how to complete the sections of the HRF 601.0 series for benefits paid for chronic disease management programs (CDMPs).

The *Private Health Insurance (Risk Equalisation Policy) Rules 2007* provide that only benefits paid for planning, coordination and allied health service components of CDMPs are eligible for risk equalisation. Programs must also meet the definition of CDMP set out in the *Private Health Insurance (Health Insurance Business) Rules 2013*.

The duration of, and diversity of various components of CDMPs mean that health insurers may have varying arrangements for the payment of benefits. Benefits may be paid on a per service basis, on a per program basis (either as a single payment or in instalments) or by directly employing staff to deliver programs.

When to report on CDMPs

Information on CDMPs should be reported in the quarter that benefits were paid for the program, regardless of whether the benefits are paid on a per service, or per program, basis.

In the case where the health insurer employs their own staff to deliver services, benefits should be reported in the quarter that the services were delivered.

How to report the amount of benefits paid for CDMPs

Part 8 of HRF 601.1 calls for benefits paid for planning, coordination and allied health services to be reported separately, as these are the only components of a CDMP that are eligible benefits for risk equalisation.

Part 8 also contains a field for ‘other’ benefits paid for the program that are ineligible for risk equalisation. In the future, this data will inform decisions about extending the risk equalisation arrangements to other costs for CDMPs.

If benefits are paid on a per program basis, or the program is delivered by a salaried employee of the health insurer, the health insurer must attribute specific amounts for planning, coordination, allied health services and ‘other’ so that the amount of benefit paid is accurately reported.

The amount of benefit reported depends upon the way benefits are paid for the CDMP.

1. Benefits paid on a per-service basis for components of a CDMP

If benefits are paid on a per service basis for planning, coordination, and any allied health and/or other goods and services as part of a CDMP on the basis of separate accounts rendered by providers, the completion of HRF 601.1 is straightforward.

2. Benefits paid on a per program basis

If benefits are paid on a per program basis in a single payment, the amount of the benefit must be disaggregated for each of the service components and the number of times services were delivered, and reported against the relevant field in Part 8 of HRF 601.1.

If benefits are paid in instalments, disaggregated benefits should be apportioned to the amount of the instalment.

It is expected that when negotiating the cost of the program with a provider, health insurers would identify the various cost components and the expected frequency of the services to be delivered.

3. Health insurer employs staff to deliver a CDMP

If a health insurer employs staff to deliver CDMPs (e.g. to plan and coordinate programs), the costs that are directly related to the employment of staff can be risk equalised. These costs are the salaries plus on-costs (or overheads).

The fields under the column 'benefits paid' should be reported by taking the total cost of employing staff in the quarter and dividing it by the number of services provided in that quarter. For example, a health insurer employs two full time staff at a cost of $30,000 for the quarter. During the quarter 240 planning services and 960 coordination services were delivered. Therefore, the insurer attributes, for example, $65 for each planning service and $15 for each coordination service.

If staff were engaged in other activities, the employment costs should be apportioned according to the actual time spent providing planning and coordination services.

For auditing purposes, health insurers should also be able to demonstrate the costs of employing staff to provide planning and coordination services, and the proportion of time staff spent providing those services.

In this scenario, no fees would be charged as there should be no liability on the health insurer to pay fees or charges for the program. Accordingly, in the fields under the column 'fees excluding Medicare benefit' report the same values as the benefits paid. These fields are used as validation checks that the benefit paid is not greater than the fees. Reporting the fees as zero would create an error.

Risk Equalisation Guidelines

Quarterly Return

Part	Heading	Comment
2.	**Total Chronic Disease Management Programs (CDMP)**	**Number** – the total number of chronic disease management programs is the number of individual members who commenced programs during the quarter. **Benefits paid** – the total benefits paid is the sum of all benefits paid for CDMPs in the quarter. Note: health management programs are not included (these are to be included in Part 6 and 9).
5.	**Chronic Disease Management Program by age category**	Details are to be completed separately for males and females. **Insured persons** – the number of insured persons who hold policies that cover CDMPs, in the age cohort they are in at the end of the quarter. **Programs** – the number of insured persons commencing CDMPs during the quarter. If one person commenced two CDMPs during the quarter, this should be reported as two. **Eligible benefits** – eligible benefits are defined in Rule 5 of the *Private Health Insurance (Risk Equalisation Policy) Rules 2007*.

		Ineligible benefits – all other benefits paid for CDMPs in the quarter not included in Rule 5 of the *Private Health Insurance (Risk Equalisation Policy) Rules 2007*. Note: health management programs are not included (these are to be included in Part 6 and 9). **Total benefits** – sum of eligible plus ineligible benefits paid for CDMPs in the quarter. **Fees excluding Medicare benefit** – report fees charged by providers, as health insurers are precluded from paying benefits for out-of-hospital services for which a Medicare benefit is payable (except in the circumstances outlined in Rule 10 General treatment – services for which Medicare benefit is payable of the *Private Health Insurance (Health Insurance Business) Rules 2013*.
6.	**General Treatment by age category**	Note: information on health management programs is reported here.
8.	**Benefits paid for CDMPs**	Definitions of planning, coordination and allied health services for the delivery of CDMPs are provided in Rule 12 of the *Private Health Insurance (Health Insurance Business) Rules 2013*. **Services** – the total number of goods and services that benefits were paid for in the quarter. **Benefits** – the total amount of benefits paid for goods and services in the quarter. **Fees charged** – the total amount of fees charged by providers for goods and services in the quarter.
	Benefits paid by Program Type	This is a breakdown of the types of CDMPs that benefits were paid for during the quarter. **Programs** – the number of insured persons commencing CDMPs that during the quarter. If one person commenced in two CDMPs, this should be reported as two. **Benefits** – the total amount of benefits paid for goods and services in the quarter. **Fees charged** – the total amount of fees charged by providers for goods and services in the quarter.
9.	**Benefits paid for General Treatment (excluding Hospital-Substitute Treatment and CDMP)**	Note: information on health management programs is reported here.

Attachment – HRF 601.0 series Data Dictionary

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About the Data Dictionary

This dictionary is a compilation of definitions for terms used or associated with the HRF 601.0 series in the order in which they appear in the template.

All definitions that come from current legislation are cited underneath.

Current legislation includes:

- *Private Health Insurance Act 2007;*
- *Private Health Insurance (Health Insurance Business) Rules 2013;*
- *Private Health Insurance (Risk Equalisation Policy) Rules 2007;*
- *Private Health Insurance (Risk Equalisation Administration) Rules 2015; and*
- *Health Insurance Act 1973.*

Terms in the leftmost column show the correct style of use for these terms.

All defined terms are listed in the Index.

Part 1 Policies and insured persons

Term	Definition
adult	Means a person who is not a dependent child. *(Schedule 1, Private Health Insurance Act 2007)*
cover	(1) An insurance policy covers a treatment if, under the policy, the health insurer undertakes liability in respect of some or all loss arising out of a liability to pay fees or charges relating to the provision of goods or a service that is or includes that treatment. (2) An insurance policy also covers a treatment if the insurer provides an insured person, or arranges for an insured person to be provided with, goods or a service that is or includes that treatment. (3) If an insurance policy covers a treatment in the way described in subsection (2), this Part applies as if the provision of the goods or service were a benefit provided under the policy. *(Division 69, Private Health Insurance Act 2007)*
Coverage requirements coverage requirements	(1) An insurance policy meets the coverage requirements in Division 69 if: (a) the only treatments the policy covers are: (i) specified treatments that are hospital treatment; or (ii) specified treatments that are hospital treatment and specified treatments that are general treatment; or (iii) specified treatments that are general treatment but none that are hospital-substitute treatment; and (b) if the policy provides a benefit for anything else—the provision of the benefit is authorised by the Private Health Insurance (Complying Product) Rules. (2) Despite paragraph (1)(a), the policy must also cover any treatment that a policy of its kind is required by the Private Health Insurance (Complying Product) Rules to cover. (3) Despite paragraph (1)(a), the policy must not cover any treatment that a policy of its kind is not allowed under the Private Health Insurance (Complying Product) Rules to cover. *(Division 69, Private Health Insurance Act 2007)*
dependent child	Means a person (a) who is:

	(i) aged under 18: or (ii) a dependent child under the rules of the insurer that insures the person; and (b) who is not aged 25 or over; and (c) who does not have a partner. *(Schedule 1, Private Health Insurance Act 2007)*
holder (of an insurance policy)	Means a person who is insured under the policy and who is not a dependent child. *(Schedule 1, Private Health Insurance Act 2007)*
Insured persons insured persons	All persons covered by health insurance policies.
policy holder Policies, policies (of a health benefits fund)	Means a holder of a policy that is referable to the fund. *(Schedule 1, Private Health Insurance Act 2007)*
private health insurance policy	Means an insurance policy that covers hospital treatment or general treatment or both (whether or not it also covers any other treatment or provides a benefit for anything else). *(Schedule 1, Private Health Insurance Act 2007)*
Single equivalent unit/s (SEU/s)	Single equivalent units (SEUs) are used as a standard measure of the different categories of policies. The Single equivalent units for each category of policy are: (a) Single—1 (b) Couple—2 (c) 2+ persons no adults—1 (d) Single parent—1 (e) Family—2 (f) 3+ adults—2 *(the Preliminary section, Private Health Insurance (Risk Equalisation Policy) Rules 2007)* SEUs are calculated as ([Single] + [2+ Persons no adults] + [Single parent]) + 2 x ([Couple] + [Family] + [3+ Adults])

Type of cover

All definitions are taken from the *Preliminary section, Private Health Insurance (Risk Equalisation Policy) Rules 2007.*

2 + persons, no adults	A policy under which 2 or more people are insured, none of whom is an adult.
3 + adults	A policy under which 3 or more people are insured, at least 3 of whom are adults.
couple	A policy under which 2 adults are insured (and no-one else).
family	A policy under which 3 or more people are insured, only 2 of whom are adults.
single	A policy under which only one person is insured.
single parent	A policy under which 2 or more people are insured, only one of whom is an adult.

Types of Policies

Excess & 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 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 $500 for a policy covering a single person or an excess no greater than $1,000 for a policy covering more than one person.
Excess & Co-payments	Excess & 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. Note: these can be combined with exclusionary policies. Excess (also referred to as 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.
Exclusionary Policies	Means where the private health insurance policy features an exclusion for a particular condition covered by Medicare and there is no coverage at all for medical treatment as a private patient in a public or private hospital or any other setting for that condition. Exclusionary tables exclude payment of benefits for a particular condition in all settings. (This does not refer to the case where the policy only covers the medical services to a limited extent, only in certain settings or only after a certain time.) (This does not refer to the case where the service referred to is not covered by Medicare. For example cosmetic surgery.)
No Excess & No Co-payments	Means all policies other than Excess & Co-payments Policies. The sum of Excess & Co-payments and No Excess & No Co-payments policies will reflect the total hospital treatment policies.
Non-Exclusionary Policies	Means the policy does not have any exclusions (see Exclusionary Policies). The sum of exclusionary and non-exclusionary policies will reflect the total hospital treatment policies. NB: Where a product only relates to select hospitals but covers all treatment in those hospitals the policies should be included in the non-exclusionary category. ***Errors to avoid:*** *The majority of errors that come to APRA's attention for exclusionary policy holders are where treatment is excluded in some, but not all, settings where the product can be utilised but the policy holders are counted as exclusionary. For example, if treatment is excluded in a private hospital but not excluded in a public hospital the member with that product should* ***not*** *be counted as an exclusionary policy holder.*

Changes during the quarter

Start of quarter	Means the total number of policies and insured persons with Hospital Treatment Only, Hospital Treatment and General Treatment or General Treatment Only at the start of the quarter.

	This figure should match end of quarter reported under the same categories in the previous quarter's return.
New policies/persons	Policies and insured persons joining but not transferring from another fund. This category should include: • New policies. • Reinstated policies where these policies were not included in the previous quarter's return because of suspension (note that if a policy is both suspended and reinstated within the quarter to which this return relates they should not be counted as discontinued or reinstated). • Hospital Treatment Only or General Treatment Only policies who take additional cover. • Insured persons with a General Treatment Only policy transferring to an existing Hospital Treatment policy (an increase in insured persons, not policies). • Births, or children covered under one parent's cover (increase in insured persons not policies).
Transferring from another state	Means policies and insured persons transferring from another state within this fund.
Transferring to another state	Means policies and insured persons transferring to another state.
Transferring from another Fund	Means policies and insured persons transferring from another fund but not joining. This category should include: • Policies joining as transfers from another fund. • Insured persons transferring from another fund to an existing policy (new insured persons, not new policies). • Policies with a Hospital Treatment Only policy with your fund and General Treatment Only policy with another fund who transfer the General Treatment Only policy to your fund (new Hospital and General Treatment policy).
Transferring to another policy	Means policies and insured persons transferring to another policy treatment type. Policy types being "Hospital Treatment Only", "Hospital Treatment and General Treatment" or "General Treatment Only".
Transferring from another policy	Means policies and insured persons transferring from another policy treatment type. Policy types being "Hospital Treatment Only", "Hospital Treatment and General Treatment" or "General Treatment Only".
Discontinued	Means policies and insured persons leaving. Represents the balancing item for the aggregate fund coverage from one quarter to the next. Included in this category is: • Deaths (decrease in insured persons, not necessarily

	policies). • Suspended policies, where they are not included in the coverage count for risk equalisation purposes. • Policies with "Hospital and General Treatment" that drop "Hospital Treatment" cover or drop "General Treatment Cover".
End of quarter	This equals: policies/insured persons at start of quarter *plus* new policies/insured persons joining *plus* transfers from another state, fund or policy type *less* transfers to another state or policy type *less* discontinued coverage.

Types of treatment

Chronic Disease Management Program (CDMP)	*See Page 33*
Hospital treatment hospital treatment	Meaning of hospital treatment (1) Hospital treatment is treatment (including the provision of goods and services) that: (a) is intended to manage a disease, injury or condition; and (b) is provided to a person: (i) by a person who is authorised by a hospital to provide the treatment; or (ii) under the management or control of such a person; (c) either: (i) is provided at a hospital; or (ii) is provided, or arranged, with the direct involvement of a hospital. *(Division 121, Private Health Insurance Act 2007)* *Definition for Hospital see page 28*
Hospital-substitute Treatment hospital-substitute treatment	Means general treatment that: (a) substitutes for an episode of hospital treatment; and (b) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and (c) is not specified in the Private Health Insurance (Complying Product) Rules as a treatment that is excluded from this definition.

	(Division 69, Private Health Insurance Act 2007) Note: In the Act the Coverage Requirements do not permit a general treatment policy only to include hospital-substitute treatment. Policies that include hospital-substitute treatment must also include hospital treatment.
General Treatment	*See page 37*
General Treatment Only Policies	Means policies that cover specified treatments that are general treatment but none that are hospital or hospital-substitute treatment. General Treatment Ambulance Only is included in Total General Treatment Only.
General Treatment Ambulance Only Policies	Means policies that cover ambulance services but does not cover any other hospital or general treatment. A subset of General Treatment Only Policies, covering only ambulance services. Ambulance services associated with the provision of treatment to an insured person are specified as included in General Treatment for the purposes of subsection 121-10 (2) of the *Private Health Insurance Act 2007*.
Hospital Treatment Only Policies	Means policies that specify only treatments that are hospital treatment.
Hospital and General Treatment Combined	Means policies that specify treatments that are hospital treatment and specify treatments that are general treatment.

Part 2 Total Benefits Paid for Hospital Treatment and General Treatment

episode/s	Means for a particular type of treatment or place where the treatment was provided: (a) for hospital treatment provided at a hospital, the period between the insured person's admission to the hospital and discharge from that hospital, including leave periods, is one episode; and (b) for: (i) hospital-substitute treatment; and (ii) hospital treatment that is provided, or arranged, with the direct involvement of a hospital, the continuous period between the commencement and cessation of the treatment is one episode, and (c) an episode for which a benefit has been paid is to be counted (unless an incomplete episode). Note: episodes are not reported until the episode is complete.
incomplete episode	If an episode is not completed within a quarter but a benefit has been paid in relation to the treatment because of an interim billing arrangement, the episode is reported

	as one episode only and only in the quarter in which the episode is completed.
Days - Hospital Treatment	Means day/s on which a policy holder or insured person is a patient of a public or private hospital for hospital treatment. Days must reflect the total days related to each episode, including days when no private health insurance benefits are paid. Where a hospital stay includes leave days, those days are not reported in HRF 601.1.
Days - Hospital-substitute Treatment	While there may be no accommodation benefits involved in hospital-substitute there will be days involved in the care. Either one day only or more than one day.
Benefits Paid Chronic Disease Management Program (CDMP)	Means benefits paid for services covered by Chronic Disease Management Programs.
Benefits Paid General Treatment	Means benefits paid for services covered by general treatment.
Benefits Paid Hospital Benefits	Means benefits paid for services covered by hospital treatment.
Day Hospital Facilities	Means a private hospital that is not licensed or otherwise permitted to provide treatment that includes part of an overnight stay at the hospital. Note: Day hospital facilities are those that were a day hospital facility within the meaning of the *National Health Act 1953*, and are taken to be private hospitals for the purpose of the *Private Health Insurance Act 2007*.
Day Only	Means a day on which a policy holder or insured person is accommodated as a patient in a public or private hospital for day treatment.
leave periods/leave days	Means a temporary absence from hospital treatment with medical approval for a period no greater than seven consecutive days.
Private Hospitals	Means a hospital in respect of which there is in force a statement under subsection 121-5(8) of the *Private Health Insurance Act 2007* that the hospital is a private hospital.
Public Hospitals	Means a hospital in respect of which there is in force a statement under subsection 121-5(8) of the *Private Health Insurance Act 2007* that the hospital is a public hospital.
Overnight	Means days on which a policy holder or insured person is a patient of a public or private hospital for hospital treatment for a period of time.
Hospital-Substitute	*See page 26*

Treatment	
Treatment greater than one day	For hospital-substitute treatment an episode is to be counted as the continuous period between commencement and cessation of treatment. While there may be no accommodation benefits involved in hospital-substitute there will be days involved in the care. Either one day only or more than one day. The intent is to collect data on the length of care involved in hospital-substitute.
Nursing Home Type Patients	Means a patient in the hospital who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days. *(Section 3, Health Insurance Act 1973)*
Medical benefits	Means benefits paid under all policies of the fund for services provided as part of hospital treatment or hospital-substitute treatment if a medicare benefit is payable for the service.
Prostheses benefits	Means benefits paid under all policies of the fund for prostheses of the kinds listed in the *Private Health Insurance (Prostheses) Rules 2009* made under the Act, but only where those Rules provide that there must be a benefit for the provision of the prosthesis in the circumstances specified.
Ineligible benefits	*See page 32*

Risk Equalisation

Age Based Pool (ABP) age based pool	The Age Based Pool (ABP) equalises benefits for the Risk Equalisation Levy. Pooling is based on adding a proportion of applicable benefits, above age 55, in a sliding scale. The amount to be notionally allocated to the ABP in a quarter is to be calculated in accordance with the formula **pC**, where: (a) **p** is the percentage of the eligible benefit paid having regard to the age cohort, as specified in the ABP table, into which the insured person falls on the day or days on which the insured person receives the treatment to which the eligible benefit relates; and (b) **C** is the gross benefit in the current quarter. Where an insured person receives treatment over a number of days such that the age of the insured person on the day or days on which that person receives the treatment falls within more than one age cohort, the amount to be notionally allocated to the ABP must be allocated proportionately in accordance with the number of days during which the insured person was in each age cohort.

	(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2007)
ABP table	see table below

Age cohorts	**Age % of eligible benefits included in pool**
0-54	0.0%
55-59	15.0%
60-64	42.5%
65-69	60.0%
70-74	70.0%
75-79	76.0%
80-84	78.0%
85+	82.0%

(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2007)

Gross Benefit	Means the total eligible benefits paid by the insurer in respect of an insured person in a quarter.
High Cost Claimants Pool (HCCP) high cost claimants pool	The High Cost Claimants Pool (HCCP) deals with benefits not equalised by the age-based pool. Pooling is based on applicable benefits accumulated by claimant for the current and preceding 3 quarters. The percentage of the benefits to be pooled will be 82%. A limit is imposed on total pooling under the ABP pool and HCCP of 82% of gross benefits. When assessing HCCP pooling in each quarter, the cumulative residual after ABP pooling is compared with the threshold at that time. The amount to be notionally allocated to the HCCP is to be calculated in accordance with the formula m(R-T) - H, where: (a) **m** is 82% (b) **R** is the total gross benefit for the current and the preceding 3 quarters less the amount notionally allocated to the ABP in the current and preceding 3 quarters (c) **T** is the designated threshold (d) **H** is the sum of the amounts notionally allocated to the HCCP in the preceding 3 quarters Subject to a maximum of 82% of gross benefits being included in Risk Equalisation when summing the ABP and HCCP components. *(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2007*)
HCCP Claimants	Means the number of insured persons whose total eligible benefits paid by the insurer exceed the threshold after

	applying ABP.
HCCP Net Benefits	Means applicable benefits, after age based pooling, that exceed the threshold. 82% of net benefits in excess of the threshold are to be pooled.
HCCP Threshold	Means the designated threshold. The designated threshold is $50,000.
Risk Equalisation Levy	To calculate the amount of levy in respect of a current quarter: (a) an amount calculated is first to be notionally allocated to the age based pool (ABP). (b) if the amount of gross benefit not notionally allocated to the ABP in the current and preceding 3 quarters, is greater than the designated threshold, a second amount is to be notionally allocated to the high cost claimants pool (HCCP). (c) If the (ABP + HCCP)/(Average hospital SEU) for a fund is less than the equivalent state calculation then the insurer must pay into the Risk Equalisation Pool the difference per SEU. (d) If the (ABP + HCCP)/(Average hospital SEU) for a fund is more than the equivalent state calculation then the insurer will receive the difference per SEU from the Risk Equalisation Pool. *(Part 2, Private Health Insurance (Risk Equalisation Policy) Rules 2007*)

Parts 3-6 Collections by Type of Product and Age Category

Fees excluding Medicare benefit	The fees excluding Medicare benefit must exclude the medicare benefit component of the total fee charged. The difference between fees charged and total benefits paid should be the amount that the patient has to pay (gap). In some cases the fund paying the benefits will be unaware of a discount offered by the provider, for example for early payment. Fees excluding Medicare benefit should be, in cases where the discounted fee is unknown, the invoiced amount less the Medicare benefit. Fees excluding Medicare benefit should be greater or equal to the sum of benefits, medical benefits and prostheses benefits. Note: The total fee charged is the total amount the patient and Medicare would have to pay to the provider in the absence of any private health insurance.
Eligible Benefits	Means a benefit paid by an insurer for any of the following: • planning and coordination services for CDMP;

- allied health services which are provided as part of a CDMP;
- hospital-substitute treatment; and
- hospital treatment.

(Part 1, Private Health Insurance (Risk Equalisation Policy) Rules 2007)

Ineligible Benefits	Includes other benefits paid by an insurer that are not eligible.
Fees Charged	Is the known or invoiced fee charged by the provider for general treatment.
Benefits	In parts 3 and 4 means benefits paid for hospital treatment or hospital-substitute treatment. It does not include Medical, Prostheses and Ineligible benefits.
Total Benefits	Means benefits plus Medical and Prostheses benefits. It does not include Ineligible benefits.

Part 7 Total Hospital Treatment Policies by Type of Cover

Excess/Co-Payments	*See page 23* In this section Excess refers to the maximum Excess that could be payable in any one year for a policy. Any policies that commenced cover before 24 May 2000 and are exempt from the Medicare Levy Surcharge should be reported in the categories “Nil” or “<=$500/$1,000”.
Full Cover	Means policies that have no restriction on benefits paid after 12 months of cover. This could be regarded as a 100% product, with no exclusions. Policies with a co-payment and no other restriction are defined as having full cover. Where a fixed percentage of benefits is paid (e.g. 85 per cent benefit of contract fee) the 15 per cent payable by the member should be regarded as a moiety or co-payment, and therefore full cover. Products that pay, for example, 100 per cent on contracted hospitals but a fixed benefit on non-contract hospitals should be regarded as full cover. A Full Cover product may have members reported at all levels of co-payments.
Reduced cover	Means policies that restrict benefits paid after 12 months of cover. Products that have a fixed benefit regardless of the fees charged are included in the reduced benefits category. A product that pays fixed benefits will have a nil Excess/Co-payment unless a moiety is attached to the product.

Some Lifetime Exclusions	Means policies that provide no benefits for certain treatments for the life of the membership. (Note that an exclusionary product excludes certain treatments in all settings. For example, a product that does not pay benefits for certain treatment in a private hospital but does pay benefits for that treatment in a public hospital is not regarded as exclusionary).
General Treatment claims processing (excluding hospital-substitute treatment and CDMP)	This data item shows the percent of General Treatment claims (excluding hospital-substitute and CDMP) that were processed within five working days in the current quarter.
Retention index - Hospital Treatment policies	The retention index is designed to provide a performance indicator by showing the percent of policies that have remained active hospital treatment policies of the same fund for two years or more, over all states.

Part 8 Benefits Paid for Chronic Disease Management Programs

Chronic Disease Management Program (CDMP)

General Treatment cover for a Chronic Disease Management Program.

A CDMP is intended to:

- reduce complications in a person with a diagnosed chronic disease;
- prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease;
- requires the development of a written plan that:
  - specifies the allied health service or services and any other goods and services to be provided;
  - specifies the frequency and duration of the provision of those goods and services;
  - specifies the date for review of the plan;
  - has been provided to the patient for consent;
  - consent is given to the program, before any services under the program are provided; and
- is coordinated by a person who has accepted responsibility for:
  - ensuring the services are provided according to the plan; and
  - monitoring the patient's compliance.

(Part 3, Private Health Insurance (Health Insurance Business) Rules 2013)

Allied Health Services allied health services	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; • osteopath; • physiotherapist; • podiatrist psychologist; or • speech pathologist. *(Part 3, Private Health Insurance (Health Insurance Business) Rules 2013)*
Coordination	Coordination ensures that the services are provided to the patient as planned. The plan should be reviewed and adjusted if necessary. Coordination may be undertaken by a health care provider, such as a practice nurse or other allied health professional and overseen by a medical practitioner. The medical practitioner would be involved in the review process. Services provided as part of a CDMP must be coordinated as described in 12(1)(c) of the *Private Health Insurance (Health Insurance Business) Rules 2013*.
Planning	Planning commences with an assessment of the services needed to address the patient's condition and the agreed goals for the program. A plan is then made of the services or goods required and the frequency and duration of the services. Typically, a medical practitioner would undertake the assessment and formulate the plan. The plan should include arrangements to review the program in order to assess whether the intended clinical outcomes are being achieved and that the patient is complying with the plan. Services provided as part of a CDMP must be planned as described in 12(1)(b) of the *Private Health Insurance (Health Insurance Business) Rules 2013.*
Risk Factors for chronic disease	Means, but is not limited to: (a) lifestyle risk factors, including, but not limited to, smoking, physical inactivity, poor nutrition or alcohol misuse; (b) biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or

excess weight; and
(c) family history of a chronic disease.

(Part 3, Private Health Insurance (Health Insurance Business) Rules 2013)

Types of Allied Health Professionals

The eligibility criteria for allied health professionals providing new Medicare services provides definitions of each type of allied health professional eligible to claim a Medicare rebate for their services.

The definitions below are taken from: Eligibility criteria for allied health professionals providing new Medicare services. This document is published by the Department of Health and Ageing and is available at:
http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-medicare-health_pro-gp-pdf-eligibility-cnt.htm

Aboriginal Health Workers	Practising in the Northern Territory (NT) must be registered with the Aboriginal Health Workers Board of the NT; in other States and the Australian Capital Territory they must have been awarded a Certificate Level III (or higher) in Aboriginal and Torres Strait Islander Health from a Registered Training Organisation that meets training standards set by the Australian National Training Authority's Australian Quality Training Framework.
Audiologists	Must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).
Chiropractors	Must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.
Diabetes Educators	Must be a Credentialled Diabetes Educator (CDE) as credentialled by the Australian Diabetes Educators Association (ADEA).
Dietitians	Must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).
Exercise Physiologists	Must be an 'Accredited Exercise Physiologist' as accredited by the Australian Association for Exercise and Sports Science (AAESS).
Mental Health Workers	'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following: • psychologists; • mental health nurses; • occupational therapists;

	• social workers; and • Aboriginal health workers.
Psychologists, occupational therapists and Aboriginal health workers	Are eligible in separate categories for these items. A ***mental health nurse*** may qualify if they are: • a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or • a 'Credentialled Mental Health Nurse' as certified by the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), if providing mental health services in other States or the Northern Territory. To be eligible to provide mental health services for the purposes of this item, a ***social worker*** must be a 'Member' of the Australian Association of Social Workers (AASW); and be certified by AASW as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999'.
Occupational Therapists	In Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.
Osteopaths	Must be registered with the Osteopaths (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.
Psychologists	Must be registered with the Psychologists Registration Board in the State or Territory in which they are practising.
Physiotherapists	Must be registered with the Physiotherapists Registration Board in the State or Territory in which they are practising.
Podiatrists/Chiropodists	In all States and the Australian Capital Territory must be registered with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, Podiatrists/Chiropodists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a "Full Member" of the Australian Podiatry Association (APodA) in any other State or the Australian Capital Territory.

Speech Pathologists	Practising in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

Part 9 Benefits Paid for General Treatment

General Treatment	Meaning of general treatment
general treatment	(1) General treatment is treatment (including the provision of goods and services) that: (a) is intended to manage or prevent a disease, injury or condition; and (b) is not hospital treatment. *(Division 121, Private Health Insurance Act 2007)* Further information about general treatment can be found in Part 3, *Private Health Insurance (Health Insurance Business) Rules 2013.*

General Treatment categories (HRF 601.1 headings)

These are examples only based on the types of services covered under General Treatment Products. This is not a comprehensive listing of all services.

Under the new legislation some of the items historically collected in this section are considered to be excluded from General Treatment. Therefore, insurers can only provide benefits for them as part of a complying health insurance product under the provisions of the *Private Health Insurance Act* 2007 paragraph 69-1 (1) (b) and the *Private Health Insurance (Complying Product) Rules 2010* Rule 7. Some of them will be considered health related business rather than health insurance business.

Accidental Death/Funeral Expenses	Funeral parlour, burial or cremation expenses. These benefits are being phased out under paragraph 69-1 (1) (b) of the *Private Health Insurance Act* 2007 and Rule 7 of the *Private Health Insurance (Complying Product) Rules 2010*.
Acupuncture/Acupressure	Acupuncture. Acupressure.
Ambulance	Emergency ambulance transport, anywhere in Australia to the nearest appropriate hospital able to provide the level of care required, provided by an Ambulance Service OR Non-emergency ambulance transport, anywhere in Australia, provided by an Ambulance Service.
Chiropractic	Chiropractic, Chiropractic X-Rays
Community, Home, District Nursing	Treatment for illness, disease, incapacity or disability when the purpose of treatment is dependent on nursing

	care excluding hospital-substitute treatment.
Dental	Comprehensive examination or consultation. Dental X-ray. Clean, polish, Fluoride treatments. Scale & clean. Custom-made mouthguard. Tooth fillings. Crowns and bridges. Full upper or lower Denture. Major dental work. Periodontics, endodontics, dentures and surgical extraction of teeth.
Dietetics	Dietitian and nutritionist.
Domestic Assistance	A benefit for home assistance provided by councils.
Ex gratia Payments	Payments for services not covered under the rules of the insurer. For example, the insurer may pay for drugs not normally covered as a gesture of good will.
Preventative health products/Health management programs	Weight loss/ Weight management programs. Quit smoking, nicotine replacement therapy. Disease management association fees (Asthma, Diabetes, Heart, Arthritis and Coeliac). Cancer Council UV products (30+ sunscreen, rash vests and suits, hats, wrap sunglasses).
Hearing Aids and Audiology	Hearing Aids, Hearing Aid repair. Cochlear Speech Processor.
Hypnotherapy	Hypnotherapy.
Maternity Services	Pre and post natal consultation and classes. Midwife delivery services.
Natural Therapies	Alexander technique, Aromatherapy, Naturopathy, Biochemist, Bowen Therapy, Feldenkrais, Herbalist, Homeopathy, iridology, Kinesiology and One on One Pilates, Rolfing, Reflexology, Remedial Massage, Shiatsu.
Occupational Therapy	Occupational Therapy.
Optical	Single Vision glasses. Bifocal glasses. Multi-focal glasses.
Optical (continued)	Contact lenses disposable and hard. Disposable contacts. Prescription - sight correcting lenses. Frames. Repair.
Orthoptics (Eye Therapy)	Eye therapy

Osteopathic Services	Osteopathy
Overseas	Means a cover provided to a person who is not an Australian Resident, is not entitled to full Medicare benefits and is visiting Australian on a temporary or long stay visa for holiday, study or work purposes. Residents of Norfolk Island and other residents of Australian territories are deemed to be "overseas visitors" when visiting Australia. After 1 July 2008, overseas cover will not be health insurance business.
Pharmacy	Pharmaceutical. Hormonal implants. Skin contraceptives. Preventive vaccines - Hepatitis A/B Injections, Flu, Travel and other approved vaccines.
Physiotherapy	Physiotherapy.
Podiatry (Chiropody)	Podiatry, Biomechanical Assessment, Casts, Orthotics - custom made sporthotics or formthotics.
Prostheses, Aids and Appliances	Post operation aids (eg. surgical stockings), Braces and supports (eg. crutches), Medical aids (including Irlen lens), Non-surgical prosthesis (including wigs), Artificial appliances, Wheel chairs, Walking frames Nebuliser, TENS machine, asthma spacer, blood glucose monitor.
Psych/Group Therapy	Psychology.
School	Benefits paid, as a result of a personal injury to a student covered by the policy while at school or travelling to or from school or any associated school activity and not paid or payable from any other source. This benefit is for essential health care services, other than services provided in hospital or those attracting a Medicare benefit.
Sickness and Accident	Accident means an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary personal hurt or damage to the body of a person covered by a policy, which requires immediate medical advice or treatment from a registered practitioner. This General Treatment benefit is for essential health care services, other than services provided in hospital or those attracting a Medicare benefit. Note: The term "Sickness and Accident" historically included the business of undertaking liability to pay a lump sum, or make periodic payments, on the occurrence of a personal accident, disease or sickness, or was contingent on some treatment or services being provided

	to the insured, or on the payment of fees or charges for any treatment or services. The Act does not recognise payment of benefits in these circumstances as health insurance business. *(Division 121, Private Health Insurance Act 2007 and Part 4, Private Health Insurance (Health Insurance Business) Rules 2013).*
Speech Therapy	Speech therapy.
Theatre Fees	Procedure room. Outpatient theatre fee. Medical gases (such as oxygen).
Travel and Accommodation	Accommodation expenses for parent/partner to accompany a patient who is an in-patient of a public or private hospital. Travel costs where a patient receives treatment at a hospital more than a specified distance from a patient's home. In circumstances where the patient chooses not to be an in-patient.

Part 10 Lifetime Health Cover

Lifetime Health Cover Lifetime health cover	A private health insurer must increase the amount of premiums payable for hospital cover in respect of an adult if the adult did not have hospital cover on his or her lifetime health cover base day. The amount of the increase is worked out as follows: (Lifetime health cover age – 30) x 2% x Base rate
Lifetime health cover age	In relation to an adult who takes out hospital cover after his or her lifetime health cover base day, means the adult's age on the 1 July before the day on which the adult took out the hospital cover.
Lifetime health cover base day	Is generally the 1 July following the adult's 31st birthday. *(Division 34, Private Health Insurance Act 2007)*
base rate	Means the amount of premiums that would be payable for hospital cover before any discounting. If the person was born on or before 1 July 1934 then Lifetime health cover does not apply to the person. *(Division 34, Private Health Insurance Act 2007)*
Certified age of entry	Is the lifetime health cover age.
Loading	Is the percent above the base rate that the adult must pay for membership = (Lifetime health cover age – 30) x 2%

	up to a maximum of 70%.
Loading removed	A private health insurer must stop charging premiums above the base rate for hospital cover in respect of an adult, if the adult has had hospital cover: (a) for a continuous period of 10 years; or (b) for a period of 10 years that has been interrupted only by permitted days without hospital cover (none of which count towards the 10 years). *(Division 34, Private Health Insurance Act 2007)* (c) Note: permitted days without hospital cover is defined in 34-20 of the *Private Health Insurance Act 2007*.

Part 11 Total Hospital Treatment Medical Services Statistics

Agreement	Means an agreement entered into between a medical practitioner, within the meaning of that term in subsection 3 (1) of the *Health Insurance Act 1973,* and an insurer under which the practitioner agrees to accept payment by the insurer in satisfaction of the amount that would, apart from the agreement, be owed to the practitioner in relation to the treatment provided to the insured person.
No Gap Agreement	Means an agreement where the medical practitioner agrees to accept a payment by the insurer in full satisfaction of the amount owed so that there no gap, or no out of pocket expenses to be paid by the insured person.
Known Gap Agreement	Means an agreement where the medical practitioner agrees to accept a payment by the insurer in part satisfaction of the amount owed and the patient has provided informed financial consent so that the gap or out of pocket expenses to be paid by the insured person are known in advance.
No Agreement	Is where there is no agreement in place.
Amount charged	Is the amount accepted in full payment (if known), or the invoice amount. For analytical purposes the amount charged and related data are collected in ranges with reference to the MBS where the amount charged is: > MBS to 125% MBS Fee. >125% to 150% MBS Fee. >150% to 200% MBS Fee. >200% MBS Fee.
Medicare benefit	Is the amount calculated by reference to the fees for medical services set out in the table of schedule fees. Schedule fee, in relation to a professional medical service, means the fee specified in the table in respect of the service.

	A Medicare benefit in respect of a professional service is: (a) in the case of a service provided: (i) as part of an episode of hospital treatment; or (ii) as part of an episode of hospital-substitute treatment in respect of which the person to whom the treatment is provided chooses to receive a benefit from a private health insurer; an amount equal to 75% of the Schedule fee.
Fund Benefit	Is the amount the fund pays in full or part satisfaction of the amount owed to the provider in excess of the Medicare benefit.
Gap	Is the amount paid by the insured person, or their out of pocket expense, and is calculated as: (Amount charged) – (Medicare benefit) – (Fund benefit) = Gap.
No of services	Is the number of medical services for the category.
% of services	Is the number of medical services for the category as a percent of the total number of medical services over all categories.
Amount charged % of MBS	Is the total amount charged in the category divided by the Medicare benefit schedule (MBS) fee. This is calculated as: (amount charged)/[(Medicare benefit)/(0.75)]. Note: that the Medicare benefit is 75% of the schedule fee.

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