1994

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

HEALTH LEGISLATION (PRIVATE HEALTH INSURANCE REFORM) AMENDMENT BILL 1994

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Human Services and Health, the Hon Dr Carmen Lawrence, MP)

71513 Cat. No. 94 5477 3

HEALTH LEGISLATION (PRIVATE HEALTH INSURANCE REFORM) AMENDMENT BILL 1994

OUTLINE

The purposes of this Bill are to amend the National Health Act 1953, the Health Insurance Act 1973 and the Health Insurance Commission Act 1973, and to reform the private health insurance arrangements to make insurance better value for money. These reforms will provide consumers with a wider choice of health insurance product and allow consumers to purchase health cover that eliminates any "out-of-pocket" costs, through agreements made between health benefits organizations and hospitals and health benefits organizations and medical practitioners.

2. The main amendments to the National Health Act 1953 will have the effect of:

(a) replacing the current arrangements under which benefits are paid on a per diem basis, with casemix episodic payments which cover the total episode of patient care;

(b) replacing the requirement that health benefits organizations pay all hospitals amounts of benefits determined by the Commonwealth, with arrangements that allow organizations to enter into agreements with hospitals and day hospital facilities that provide for the amount to be paid to the hospital or day hospital facility;

(c) enabling health benefits organizations to enter into agreements with medical practitioners for the provision of professional services, in-hospital, which may eliminate out-of-pocket costs or allow the patient to meet a predetermined amount;

(d) establishing an independent Private Health Insurance Complaints Commissioner to provide persons who have private health insurance with access to an effective complaints handling mechanism that has investigatory, recommendatory and conciliatory powers to resolve complaints about private health insurance issues;

(e) providing for the dissemination of information about private health insurance products by the Private Health Insurance Administration Council;

(f) removing the current requirement for health benefits organizations (other than restricted membership organizations) to conduct separate health funds in each State in which they operate;

(g) requiring health benefits organizations to notify the Secretary of the Department of changes to the constitution, articles of association and rules of the organization in advance of the date on which the changes are made; and

(h) providing the Health Insurance Commission with access to documents held by health benefits organizations in relation to claims for the assignment of the 75% Medicare benefit for professional services rendered in-hospital under agreements with medical practitioners and requiring health benefits organizations to keep such records for a period of 2 years.

3. The Private Health Insurance Complaints Levy Bill 1994 imposes a levy on health benefits organizations for the purpose of covering the costs which may be incurred by the Complaints Commissioner.

4. The main amendments to the Health Insurance Act 1973 facilitate the assignment of the 75% Medicare benefit to health benefits organizations for in-hospital professional services rendered by medical practitioners who have entered into an agreement with such organizations.

5. The amendments to the Health Insurance Commission Act 1973 remove the need for Medibank Private to conduct a separate health fund in each State, but require Medibank Private to continue to maintain a national presence.

FINANCIAL IMPACT STATEMENT

6. Apart from program costs, the reform package is cost-neutral for the Commonwealth.

7. It is estimated that due to the introduction of casemix episodic payments, health benefits organizations will realise efficiency gains.

HEALTH LEGISLATION (PRIVATE HEALTH INSURANCE REFORM) AMENDMENT BILL 1994

Notes on Clauses

Clause 1 : Short title

This clause cites the title of the proposed legislation as the Health Legislation (Private Health Insurance Reform) Amendment Act 1994.

Clause 2 : Commencement

This clause provides that the commencement dates of the clauses of this Bill and its Schedules are to be as follows:

- clauses 1, 2 and 3 on the day on which the legislation receives the Royal Assent;
- clause 4 and Schedule 1 on 1 April 1995;
- clause 5 and Schedule 2 on 1 July 1995;
- clause 6 and Schedule 3 on 1 July 1996;
- clause 7 and Schedule 4 on 1 July 1997;

Clause 3 : Principal Act

This clause defines the National Health Act 1953 as the Principal Act.

Clause 4 : Amendments commencing on 1 April 1995

This clause provides that the National Health Act 1953 and the Health Insurance Act 1973 are amended as set out in Schedule 1 to this Bill.

Clause 5 : Amendments commencing on 1 July 1995

This clause provides that the National Health Act 1953 and the Health Insurance Commission Act 1973 are amended as set out in Schedule 2 to this Bill.

Clause 6 : Amendments commencing on 1 July 1996

This clause provides that the National Health Act 1953 is amended as set out in Schedule 3 to this Bill.

Clause 7 : Amendments commencing on 1 July 1997

This clause provides that the National Health Act 1953 is amended as set out in Schedule 4 to this Bill. However, this clause also provides that the removal of the definitions of "basic table" or "supplementary hospital table" shall not, until 1 July 1998, have an effect on the conditions relating to waiting periods contained in Schedule 1 of the National Health Act 1953.

Schedule 1 : Amendments commencing on 1 April 1995

Part 1 - Amendments of the National Health Act 1953

This Part amends the National Health Act 1953 as set out below. These amendments are to commence on 1 April 1995.

1. Subsection 4(1) (paragraph (da) of the definition of "basic private table" or "basic table"):

Paragraph 1 amends the definition of "basic private table" or "basic table" contained in subsection 4(1). The amendment omits paragraph (da) of the definition, and is a consequential amendment that is necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

2. Subsection 4(1) (definition of "records"):

Paragraph 2 amends the definition of "records" in subsection 4(1). The phrases "Commonwealth medical benefit or" and "registered persons" are omitted from subsection 4(1) (definition of "records") because those phrases relate to the private health insurance arrangements that were in place prior to 1 February 1984 and are therefore redundant.

3. Subsection 4(1) (paragraph (a) of the definition of "supplementary hospital table"):

Paragraph 3 amends paragraph (a) of the definition of "supplementary hospital table" contained in subsection 4(1). The omission of paragraph (a) and the replacement with a new paragraph is a consequential amendment that is necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

4. Subsection 4(1) (definition of "day hospital facility"):

Paragraph 4 amends the definition of "day hospital facility" in subsection 4(1). The existing definition of "day hospital facility" is replaced with a definition which provides that a "day hospital facility" is premises that were a day hospital facility under the

National Health Act 1953 prior to the commencement of these amendments and any premises which are declared to be a 'day hospital facility' under new subsection 5B(1). The new declaration procedures mirror those for private hospitals provided for in the new section 23EA of the Health Insurance Act 1973.

5. Subsection 4(1):

For the purposes of the implementation of casemix episodic payments, paragraph 5 inserts the following new definitions into subsection 4(1):

- "applicable benefits arrangement" is to have the meaning given to such an arrangement in new section 5A;
- "hospital purchaser-provider agreement" is an agreement entered into under new section 73BD;
- "Hospital Casemix Protocol" is the list of categories of information which is prescribed for the purposes of new paragraph 73BD(2)(c);
- "medical purchaser-provider agreement" is an agreement entered into under new section 73BDA.

6. Subsection 4(1AA):

Paragraph 6 amends subsection 4(1AA). This amendment is a consequential amendment that is necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

7 - 8. Subsection 4(1BA); Subsection 4A(1):

Paragraphs 7 and 8 omit subsections 4(1BA) and 4A(1). Those provisions are redundant as they relate to the previous private health insurance arrangements.

9. Subsection 4A(2A):

Paragraph 9 amends subsection 4A(2A). This amendment is a consequential amendment that is necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

10. After section 5:

Paragraph 10 inserts new sections 5A and 5B after section 5.

Applicable benefits arrangements

New section 5A defines an **"applicable benefits arrangement"** as an arrangement entered into between a registered health benefits organization and contributors to the health benefits fund conducted by that organization under which the contributors are covered for either or both of the following:

- hospital treatment to which a hospital purchaser-provider agreement (defined in new section 73BD) entered into by the organization relates;

- professional services provided in-hospital by a medical practitioner in circumstances where the organization has entered into a medical purchaser-provider agreement (defined in new section 73BDA) with that practitioner or in circumstances where the organization has not entered into a medical purchaser-provider agreement with that practitioner.

Such arrangements may include health cover provided under a basic table of the organization.

A definition of **"medical practitioner"** for the purposes of new section 5A is inserted which includes accredited dental practitioners and dental practitioners approved by the Minister for the purposes of the definition of "professional service" in the Health Insurance Act 1973.

Declarations in relation to day hospital facilities

New section 5B is inserted to enable the Minister to declare premises to be a 'day hospital facility'. This includes the power to declare that a day hospital facility under the old definition, i.e., the definition of "day hospital facility" prior to the commencement of these amendments, is no longer such a facility. A decision made by the Minister to make any declaration under this section is to be made in accordance with any guidelines which the Minister may make, and such guidelines are disallowable instruments under the Acts Interpretation Act 1901. Due to this amendment the declaration process for day hospital facilities now mirrors the current declaration procedures for private hospitals.

11. Subsections 66(3) and (4):

Paragraph 11 omits subsections 66(3) and 66(4) because those provisions relate to the private health insurance arrangements which were in place prior to 1 February 1984, and are therefore redundant.

12. After section 67A:

Paragraph 12 creates a new Division: "Division 2 - Registration". This Division shall encompass sections 68 to 73.

13 - 14. Subsection 73(2AA); Subsection 73(2AB):

Paragraphs 13 and 14 amend subsections 73(2AA) and 73(2AB). The reference to subsection 73(2) in subsections 73(2AA) and 73(2AB) are redundant because subsection 73(2) was repealed in 1992.

15. Subsection 73(2AC):

Paragraph 15 omits subsection 73(2AC). Subsection 73(2AC) is redundant because it applies to subsection 73(2) which was repealed in 1992.

16. After section 73:

Paragraph 16 inserts a Division heading: "Division 3 -Conditions of Registration". This Division includes sections 73A to 73BC.

17. After section 73A:

Paragraph 17 inserts new section 73AB after section 73A:

Registered health benefits organization to provide information

New section 73AB is inserted to require registered health benefits organizations, as a condition of registration, to submit data in accordance with the categories of information listed in the Hospital Casemix Protocol (which is to be prescribed), unless the Secretary has agreed otherwise. The data is to be submitted to the Secretary of the Department of Human Services and Health and the Private Health Insurance Administration Council. The data is to be provided within 28 days of the end of the month to which that data relates. However, the Secretary may agree on a longer time period for the provision of data, e.g. the Secretary may agree that an organization shall supply data relating to a 2 month period in which case the data is to be provided within 28 days of the end of that 2 month period.

The information supplied under new section 73AB is to be used by the Department of Human Services and Health and the Private Health Insurance Administration Council for the purposes of modelling, evaluation and research only.

18 - 19. Subsection 73BB(2); Subsection 73BB(4):

Paragraphs 18 and 19 amend subsections 73BB(2) and 73BB(4). The substitution of new subsection 73BB(2) for subsection 73BB(2) and the amendment to subsection 73BB(4) are consequential amendments that are necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

20. After subsection 73BB(4):

Paragraph 20 inserts a new subsection 73BB(4A). New subsection 73BB(4A) inserts a requirement for calculating the amount which may be debited to an organization's Reinsurance Account in circumstances where the payment of a benefit to a contributor is a payment made in accordance with an applicable benefits arrangement which is not a basic table. New subsection 73BB(4A) provides that this payment is to be converted into an amount in respect of every day covered by the payment on which the contributor is a patient, by dividing the total amount of the payment by the episode duration in relation to that payment. The episode duration in relation to a casemix episodic payment is to be determined in accordance with the information provided to an organization under the Hospital Casemix Protocol.

21. Subsection 73BB(5):

Paragraph 21 amends subsection 73BB(5). The amendment to subsection 73BB(5) is a consequential amendment that is necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

22. After subsection 73BB(5):

Paragraph 22 inserts a new subsection 73BB(6) after subsection 73BB(5). New subsection 73BB(6) inserts a requirement for calculating the amount which may be debited to an organization's Reinsurance Account in circumstances where the payment of a benefit to a contributor is a payment made in accordance with an applicable benefits arrangement other than a basic table, and the contributor has reached the age which is prescribed. New subsection 73BB(6) provides that the amount to be debited is worked out by:

(i) dividing the total amount of the payment by the episode duration in relation to the payment (the episode duration in relation to a payment is to be determined in accordance with the information provided to an organization under the Hospital Casemix Protocol); and

(ii) multiplying the result in (i) by the number of those prescribed days referred to in (i) on which the contributor had reached the age which is prescribed.

For example, if the prescribed age is 65 and the prescribed episode duration in relation to the payment is 10 days but the contributor was 65 years of age for only 3 of those 10 days, the amount of the payment is to be divided by 10 and then multiplied by 3.

23. Subsection 73BB(11):

Paragraph 23 inserts a definition of "**episode duration**" into subsection 73BB(11). This definition, in relation to a payment made in accordance with an applicable benefits arrangement (other than a basic table), refers to the number of days that are to be determined in accordance with the information provided to a registered organization under

the Hospital Casemix Protocol.

24. After subsection 73BB(11):

Paragraph 24 inserts a new subsection 73BB(11A). New subsection 73BB(11A) provides that a reference to an applicable benefits arrangement, for the purposes of section 73BB, includes a reference to an arrangement under which a contributor has elected to contribute for the payment of lesser benefits in lieu of the full range of benefits which are payable in accordance with that arrangement.

25. Paragraphs 73BB(12)(a), (b) and (c):

Paragraph 25 amends paragraphs 73BB(12)(a), (b) and (c). The substitution of new paragraphs 73BB(12)(a) and (b) for the existing paragraphs is a consequential amendment that is necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

26. Subsection 73BC(1):

Paragraph 26 amends subsection 73BC(1). The insertion of the phrase "and the States and Territories" after "the Commonwealth" in subsection 73BC(1) is a consequential amendment which is necessary because of the insertion of new subsection 73BC(4), which permits the States and Territories to share the reinsurance liability with the Commonwealth and registered organisations.

27. After subsection 73BC(3):

Paragraph 27 inserts new subsection 73(BC)(4). New subsection 73BC(4) permits the States and Territories to make contributions towards the Health Benefits Reinsurance Trust Fund for the purpose of sharing the reinsurance liability with the Commonwealth and registered organizations.

28. Paragraph 73BC(5)(a):

Paragraph 28 amends paragraph 73BC(5)(a). The phrase "in the financial year ending on 30 June 1989" has been omitted from paragraph 73BC(5)(a) because it is redundant.

29. After section 73BC:

Paragraph 29 inserts two new Division headings and new sections 73BD and 73BDA after section 73BC.

The first Division heading is to be "Division 4 -Purchaser-provider agreements" and includes new sections 73BD and 73BDA.

Hospital purchaser-provider agreements

New section 73BD is inserted to enable health benefits organizations to enter into agreements with hospitals and day hospital facilities. These agreements are to be known as hospital purchaser-provider agreements and must include provisions that:

- the amount paid to the hospital or day hospital facility under the agreement is full payment for the services received in-hospital by an eligible contributor to the health benefits organization which is a party to the agreement, unless the agreement states otherwise;

- payments made under the agreement to the hospital or day hospital by the health benefits organization are to be made on either a casemix episodic payment basis or in accordance with the basic/supplementary hospital table structure or by a combination of the two modes of payment;

- include the level of hospital accommodation that the hospital or day hospital facility is to provide to eligible contributors to the health benefits organization which is a party to the agreement;

- requires that the hospital or day hospital facility renders a single account, which covers all the hospital related services that were provided to the eligible contributor, in respect of an episode of hospital treatment;

- requires the hospital or day hospital facility to provide information of the type specified in the Hospital Casemix Protocol, which is prescribed, to the health benefits organization that is a party to the agreement, unless the Secretary of the Department of Human Services and Health agrees that the hospital or day hospital facility does not have to provide all such information.

For the purposes of a hospital purchaser-provider agreement in new section 73BD an **"eligible contributor"** is defined as a person who contributes to a health benefits fund conducted by the health benefits organization that is a party to the agreement and who has health cover which covers the episode of hospital treatment to which the account rendered under the agreement relates.

For the purposes of a 'hospital purchaser-provider agreement' in new section 73BD, a **"casemix episodic payment"** is defined as a payment that is made in respect of an episode of hospital treatment that is set out in a prescribed list of treatments and the amount of which is set in accordance with the terms of the hospital purchaser-provider agreement. The prescribed list of treatments may be a list of 'Australian Diagnosis Related Groups' and/or a list of other treatments.

Medical purchaser-provider agreements

New section 73BDA is inserted to enable health benefits organizations to enter into agreements with medical practitioners (which includes accredited and approved dental

practitioners). These agreements are to be known as medical purchaser-provider agreements and will enable health benefits organizations and medical practitioners to voluntarily negotiate fees arrangements on any agreed basis. However, such agreements must include provisions that:

- specify that the amount paid to the medical practitioner under the agreement is full payment for the professional services received in-hospital by the eligible contributor to the health benefits organization which is a party to the agreement, unless the agreement states otherwise;

- provide that the organization agrees to accept an assignment of the medicare benefit from the eligible contributor that is effected by new subsection 20A(2A) of the Health Insurance Act 1973;

- determine the agreed level of remuneration that the organization will pay to the medical practitioner;

- provide that the account for professional services rendered by the medical practitioner will be forwarded directly to the health benefits organization which is a party to the agreement;

- provides that the account for services rendered by the medical practitioner is to include details of any amounts which the medical practitioner is to charge the eligible contributor directly.

A medical purchaser-provider agreement may apply to all professional services rendered by a medical practitioner or may be limited to certain types of professional services that are specified in the agreement.

For the purposes of a medical purchaser-provider agreement in new section 73BDA, an **"eligible contributor"** is defined as a person who contributes to a health benefits fund conducted by the health benefits organization that is a party to the agreement and who has health cover which covers the professional service to which the account rendered under the agreement relates.

A **"professional service"** to which a medical purchaser-provider agreement in new section 73BDA relates is a service that is provided to an eligible contributor whilst that person is a patient in a hospital or day hospital facility and for which a medicare benefit may be claimed by the contributor.

A definition of **"medical practitioner"** for the purposes of new section 73BDA is to be inserted, and includes accredited dental practitioners and dental practitioners approved by the Minister for the purposes of the definition of "professional service"' in the Health Insurance Act 1973.

The second Division heading is to be "Division 5 -Directions by the Minister" and includes sections 73BE to 73D.

30-38. Subsection 73BE(5); Paragraph 73BF(1)(a); Subsection 73BF(1); Subparagraphs 73BF(3)(c)(i) and 73BF(4)(a)(i); Paragraph 73BF(4)(a); Subsection 73BFA(1); Subparagraph 73BFA(3)(c)(i); Subsection 73BFB(1) and Paragraph 73BFB(4)(a):

Paragraphs 30 to 38 amend the above. The amendments to subsection 73BE(5); paragraph 73BF(1)(a); subsection 73BF(1); subparagraphs 73BF(3)(c)(i) and 73BF(4)(a)(i); paragraph 73BF(4)(a); subsection 73BFA(1); subparagraph 73BFA(3)(c)(i); subsection 73BFB(1) and paragraph 73BFB(4)(a) are consequential amendments that are necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

39. After section 73D:

Paragraph 39 inserts a new Division heading "Division 6 - Miscellaneous" after section 73D. This Division includes section 73F to section 82.

40. Sections 73F and 73G:

Paragraph 40 repeals sections 73F and 73G. Section 73F is omitted because it relates to the operation of the private health insurance arrangements which existed prior to 1 February 1984 and is therefore redundant. Section 73G is omitted as it relates to the operation of section 73F and is therefore also redundant.

41. Subsection 75(6):

Paragraph 41 amends subsection 75(6). The reference to section 73AA in subsection 75(6) (definition of "registered organisation") is omitted because, for the purposes of subsection 75(6), the reference to section 73AA is redundant.

42. Subsection 78(1):

Paragraph 42 amends subsection 78(1). The amendment to subsection 78(1) is a consequential amendment that is necessary because of the introduction of the new notification procedures for any changes to the constitution, articles of association or rules of a registered organization. These new notification procedures are set out in new subsections 78(1A), (1B) and (1C).

43. After subsection 78(1):

Paragraph 43 inserts new subsections 78(1A), (1B) and (1C). These new subsections replace the requirement that a registered health benefits organization must notify the Secretary of a change to its constitution, articles of association or rules of the organization after that change has been made, with a requirement that the organization must notify the Secretary in advance of that change.

New subsection 78(1A) requires a registered health benefits organization to notify the Secretary of a change 7 days in advance of the change if it relates to the payment of premiums by contributors to funds conducted by that organization, or 60 days in advance for other changes. New subsection 78(1A) also provides that if an organization applies to the Minister, the Minister may determine a lesser period of time for advance notification of any change.

New subsection 78(1B) provides that the Secretary must give the organization, within a reasonable period of time, written acknowledgement of the receipt of a notification of a change from the organization.

New subsection 78(1C) requires notification of a change to be in writing in a form approved by the Minister.

44. Subsection 82(6):

Paragraph 44 amends subsection 82(6) removes the reference to benefits being paid to contributors. This amendment is necessary as new section 73BD allows for hospital purchaser-provider agreements under which the registered health benefits organization, not the contributor to the organization, pays the hospital or day hospital facility for their treatment of the contributor.

45 - 48. Subsection 140(2); Paragraph (b) of Schedule 1; Subparagraph (ba)(i) of Schedule 1; Paragraph (ba) of Schedule 1

Paragraphs 45 to 48 amend the above. The amendments to subsection 140(2); paragraph (b) of Schedule 1; subparagraph (ba)(i) of Schedule 1 and paragraph (ba) of Schedule 1 are consequential amendments that are necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

49. Subparagraph (bc)(i) of Schedule 1:

Paragraph 49 omits subparagraph (bc)(i) of Schedule 1 and substitutes a new subparagraph. This amendment to subparagraph (bc)(i), which omits reference to ailments of a kind determined by the Minister, is a consequential amendment which is necessary because of the insertion of a new definition of "pre-existing ailment" in new paragraph (kc).

50. After paragraph (bc) of Schedule 1:

Paragraph 50 inserts new paragraph (bd) into Schedule 1. New paragraph (bd) imposes a condition of registration on registered health benefits organizations. New paragraph (bd) requires an organization to have an applicable benefits arrangement under which contributors are entitled to contribute for benefits in respect of an episode of treatment, whether that treatment be an episode of hospital treatment to which a casemix episodic

payment or basic table applies, or a professional service rendered in-hospital for which a medicare benefit is payable. This new paragraph ensures that contributors will be able to select a product which allows them to receive benefits for all treatment in a hospital or day hospital facility.

New paragraph (be) of Schedule 1 requires health benefits organizations to allow all contributors, and all persons eligible to become contributors, to a fund conducted by the organization, to contribute for benefits in accordance with an arrangement referred to in new paragraph (bd).

51 - 52. Paragraph (d) and (e) of Schedule 1:

Paragraphs 51 and 52 amend paragraphs (d) and (e) of Schedule 1. New paragraph (d) of Schedule 1 is substituted for existing paragraph (d) and the phrase "to a contributor" is omitted from paragraph (e) for the purpose of clarifying that paragraph (d) does not apply to nursing-home type patients.

53. After paragraph (e) of Schedule 1:

Paragraph 53 inserts new paragraph (ea) into Schedule 1. New paragraph (ea) imposes a condition of registration on registered health benefits organizations. New paragraph (ea) provides that the rate of benefit payable by an organization for a contributor's treatment, while in a hospital or day hospital facility, by a medical practitioner who has not entered into a medical purchaser-provider agreement with that organization, is 25% of the Schedule fee relating to payment of the medicare benefit in the Health Insurance Act 1973 if medical expenses incurred are greater or equal to the Schedule fee, or, if the medical expenses incurred are less than the Schedule fee, the amount by which the expenses exceed 75% of the Schedule fee.

54 - 56. Paragraph (f) of Schedule 1; paragraph (g) of Schedule 1; and subparagraph (g)(ii) of Schedule 1:

Paragraphs 54 to 56 amend the above paragraphs and subparagraph. The amendments to paragraph (f) of Schedule 1; paragraph (g) of Schedule 1 and subparagraph (g)(ii) of Schedule 1 are consequential amendments that are necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

57. After paragraph (h) of Schedule 1:

Paragraph 57 inserts a new paragraph (ha) to Schedule 1. New paragraph (ha) of Schedule 1 imposes a condition of registration on registered health benefits organizations. New paragraph (ha) requires an organization to provide contributors to a fund conducted by it with access to up-to-date lists of the hospitals and day hospital facilities with which the organization has entered into hospital purchaser-provider agreements, and also to provide those contributors with access to up-to-date lists of the medical practitioners with

whom the organization has entered into medical purchaser-provider agreements.

58. Paragraph (j) of Schedule 1:

Paragraph 58 amends paragraph (j) of Schedule 1. The amendment to paragraph (j) of Schedule 1 is a consequential amendment that is necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

59. Paragraph (k) of Schedule 1:

Paragraph 59 amends paragraph (k) of Schedule 1. The amendment to paragraph (k) of Schedule 1 substitutes the reference to "a basic table" with "an applicable benefits arrangement", and is a consequential amendment that is necessary because of the introduction of casemix episodic payments. The amendment to paragraph (k) which omits the reference to ailments of a kind determined by the Minister is a consequential amendment which is necessary because of the insertion of a new definition of "pre-existing ailment" in new paragraph (kc).

60. Subparagraph (k)(i) of Schedule 1:

Paragraph 60 amends subparagraph (k)(i) of Schedule 1. The amendments to subparagraph (k)(i) of Schedule 1 are consequential amendments that are necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

61. After paragraph (k) of Schedule 1:

Paragraph 61 inserts new paragraphs (ka), (kb), (kc) and (kd) into Schedule 1.

New paragraph (ka) of Schedule 1 imposes a condition of registration on registered health benefits organizations. The new condition provides that where a contributor is entitled to benefits in accordance with an applicable benefits arrangement (the previous arrangement) and that arrangement is replaced by another applicable benefits arrangement, the organization is to count any portion of the waiting period already served by the contributor in relation to the previous arrangement, towards any waiting period referred to in paragraphs (j) and (k).

New paragraph (kb) of Schedule 1 imposes a condition of registration on registered health benefits organizations. The new condition provides that where a contributor is entitled to benefits in accordance with an arrangement based on a supplementary hospital table of an organization (the previous arrangement) and that arrangement is replaced by an applicable benefits arrangement, the organization is to count any portion of the waiting period already served by the contributor in relation to the previous arrangement, towards any waiting period that is referred to in paragraphs (j) and (k).

New paragraphs (kc) and (kd) of Schedule 1 insert a definition which provides that a **"pre-existing ailment"** exists in circumstances where, in the opinion of a medical practitioner (who is appointed by the health benefits organization and has examined relevant information including information supplied to that practitioner by the contributor's medical practitioner), signs or symptoms of that ailment or illness were exhibited by the contributor at any time during the 6 months prior to the day on which the contributor commenced to contribute for benefits (either in accordance with an applicable benefits arrangement or in accordance with a basic table or supplementary hospital table under the arrangements that were in place prior to these amendments).

62. Paragraph (la) of Schedule 1:

Paragraph 62 omits paragraph (la) of Schedule 1 and replaces it with new paragraphs (la) and (laa).

The substitution of new paragraph (la) of Schedule 1 for existing paragraph (la) (which defines "transferred contributor" in relation to transferring between registered organizations), is a consequential amendment that is necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

For the purposes of the consequential amendment to paragraph (la), new paragraph (laa) of Schedule 1 inserts a definition of **"comparable benefits arrangement"**. New paragraph (laa) provides that:

- if the benefits for which the transferred contributor is to contribute are included in an applicable benefits arrangement (whether or not the arrangement is one under which a contributor has elected to contribute for the payment of lesser benefits in lieu of the full range of benefits which are payable in accordance with that arrangement), a comparable arrangement of the organization from which the contributor is transferring is an applicable benefits arrangement;

- if the benefits for which the transferred contributor is to contribute are included in a basic table (whether or not the contributor has elected to contribute for the payment of lesser benefits in lieu of the full range of benefits which are payable in accordance with that table), a comparable arrangement is a basic table of the organization from which the contributor is transferring;

- if the benefits for which the transferred contributor is to contribute are included in a supplementary hospital table, a comparable arrangement is a supplementary hospital table of the organization from which the contributor is transferring; or

- if the benefits for which the transferred contributor is to contribute are included in any other table, a comparable arrangement would be a corresponding table of the organization from which the contributor is transferring.

63 - 65. Sub-subparagraph (ld)(i)(A) of Schedule 1; Paragraph (m) of Schedule 1; Subparagraphs (m)(i), (ii) and (iii) of Schedule 1:

Paragraphs 63 to 65 amend the above paragraphs, subparagraphs and sub-subparagraphs. The amendments to sub-subparagraph (ld)(i)(A) of Schedule 1 and paragraph (m) of Schedule 1 (including subparagraphs (m)(i), (ii) and (iii)) are consequential amendments that are necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

66. Paragraphs (o) and (p) of Schedule 1:

Paragraph 66 omits and replaces paragraphs (o) and (p) of Schedule 1. Paragraphs (o) and (p) are omitted because those paragraphs relate directly to sections 73F and 73G which are redundant.

New paragraph (o) of Schedule 1 imposes a condition of registration on registered health benefits organizations. New paragraph (o) requires an organization to comply with a request from the Health Insurance Commission to give the Commission access to any document relating to the payment of a medicare benefit in circumstances where payment of that benefit has been assigned to the organization under new subsection 20A(2A) of the Health Insurance Act 1973.

New paragraph (p) of Schedule 1 imposes a condition of registration on registered health benefits organizations. New paragraph (p) requires an organization to retain any document relating to the payment of a medicare benefit (in circumstances where payment of that benefit has been assigned to the organization under new subsection 20A(2A) of the Health Insurance Act 1973) for a period of 2 years from the date on which the claim was lodged with Medicare for payment of the benefit or 2 years from the date on which the most recent claim was lodged.

Part 2 - Amendments of the Health Insurance Act 1973

67 - 68. Paragraph 10(2)(a) and subsection 10AC(1) (definition of "relevant service"):

Paragraphs 67 and 68 amend paragraph 10(2)(a) and subsection 10AC(1)(definition of "relevant service"). The amendments are consequential amendments that are necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

69. After subsection 20A(2):

Paragraph 69 inserts a new subsection 20A(2A). New subsection 20A(2A) provides that where a medicare benefit is payable to a contributor to a fund conducted by a registered health benefits organization which has entered into a medical purchaser-provider

agreement with the medical practitioner who provided the professional service that will attract the benefit, the right to claim the medicare benefit is automatically assigned to the organization. Prior to this amendment, medicare benefits were paid directly to the contributor unless he or she assigned the right to claim the benefit to the medical practitioner who performed the service, under the bulk-billing arrangements.

70. Section 23EA:

Paragraph 70 adds new subsections to section 23EA. New subsections 23EA(4), 23EA(5) and 23EA(6) provide that the Minister may make guidelines in writing relating to the making of declarations that premises are, or are no longer, private hospitals. This mirrors the power given to the Minister by new section 5B to make guidelines in relation to the declaration of a day hospital facility.

71 - 72. Section 39 (definition of "eligible person"); Subsection 126(5A):

Paragraphs 71 and 72 amend section 39 (definition of "eligible person") and subsection 126(5A) respectively. The amendments are consequential amendments that are necessary because, with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement.

Schedule 2 : Amendments commencing on 1 July 1995

Part 1 - Amendments of the National Health Act 1953

This Part amends the National Health Act 1953 as set out below. These amendments are to commence on 1 July 1995.

1 - 3. Subsection 4(1) (definition of "contributor", "dependant" and "registered health benefits organisation"):

All registered health benefits organizations are to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed. Paragraphs 1 to 3 insert consequential amendments which reflect the removal of this requirement by providing, for example, that the phrase "a health fund" is to be replaced with "the health fund".

4. Subsection 4(1) (definition of "waiting period"):

Paragraph 4 amends the definition of waiting period in subsection 4(1). The substitution of the new definition of "waiting period" for the existing definition is necessary because with the introduction of casemix episodic payments, benefits payable in accordance with a basic table of a registered health benefits organization are to be payable under an applicable benefits arrangement. The new definition provides that a waiting period in relation to health cover is the period that begins when a person starts contributing to an arrangement for the provision of health benefits, and ends when the person becomes entitled to receive benefits in accordance with that arrangement.

5. Subsection 4(6):

All registered health benefits organizations are to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed. Paragraph 5 inserts consequential amendments which reflect the removal of this requirement.

6. Section 4A:

Paragraph 6 repeals section 4A. Section 4A is repealed because it has been replaced by the new definition of "waiting period" in subsection 4(1).

7 - 8. Subsection 5A(1); Subsections 66(5), (6) and (7):

All registered health benefits organizations are to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed. Paragraphs 7 and 8 insert consequential amendments which reflect the removal of this requirement.

9 - 10. Subsection 67(4) (definition of "health insurance business"):

Paragraph 9 adds a note to the definition of "health insurance business" in subsection 67(4) which refers to the new subsections 67(5)and (6).

Paragraph 10 adds a definition of "employee health benefits scheme" into subsection 67(4) which covers arrangements funded by employers under which employers reimburse employees for fees or charges incurred by those employees in respect of hospital treatment or ancillary health benefits. This includes arrangements where the employee is not required to pay contributions or where the arrangement is managed as a discretionary trust. The Minister has the power to determine that a particular arrangement is not an "employee health benefits scheme".

11.Section 67:

Paragraph 11 adds new subsections 67(5) and (6).

New subsection 67(5) provides that if an employer that is conducting an employee health benefits scheme is a corporation of the kind that comes within paragraph 51(xx) of the Constitution, the employer is a body corporate incorporated in a Territory, or the employer carries on business in a Territory, an employee health benefits scheme is not precluded from coming within the definition of "health insurance business" in section 67 even if the scheme does not constitute a business of 'undertaking liability by way of insurance'.

New subsection 67(6) provides that if the employee health benefits scheme constitutes State insurance within the meaning of paragraph 51(xiv) of the Constitution, new subsection 67(5) does not apply to that scheme.

12. Subsections 68(1), (1B), (1C) and (1D):

Paragraph 12 omits subsections 68(1), (1B), (1C) and (1D). The effect of these omissions are that the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed. All registered health benefits organizations are to operate single national funds.

13 - 68. Subsection 68(2); Paragraphs 68(2)(a) and (b); Subparagraphs 68(2)(c)(ii), (iii), (iv), (v) and (vi); Paragraph 68(2A)(c); Subsections 68(3) and (4); Subsections 69(1) and (2); Sections 71, 72 and 72A; Paragraphs 72A(a), (b), (c) and (d); Subsection 73(2A); Paragraph 73(7)(b); Subsections 73(9) and (10); Subsections 73BAB(1), (1A), (1B) and (2); Subsections 73BB(1), (4), (5) and (7)(a); Subsection 73BC(12); Paragraphs 73BD(2)(a), 73BD(3)(a) and 73BDA(4)(a); Paragraphs 73BE(1)(a), (b), (c) and (d); Subsection 73BE(2); Paragraph 73BF(1)(a); Subsection 73BF(1); Paragraph 73BF(2)(a); Subparagraph 73BF(3)(c)(i); Paragraph 73BF(4)(a); Subsection 73BF(5); Subsection 73BFA(1); Paragraph 73BFA(2)(a); Subparagraph 73BFA(3)(c)(i); Subsections 73BFA(4) and (5); Paragraph 73BFB(1)(a); Subsection 73BFB(1); Paragraph 73BFB(2)(a); Subparagraph 73BFB(3)(c)(i); Subsection

73BFB(4); Paragraph 73BFB(4)(a); Paragraph 73D(2)(a); Sections 74B and 74BA; Subsection 74C(1); Subsections 79(3), (5) and (6); Paragraph 82(1)(a):

All registered health benefits organizations are to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed. The above paragraphs insert consequential amendments which reflect the removal of this requirement by providing, for example, that the phrase "a health fund" is to be replaced with "the health fund".

69. After paragraph 82G(b):

Paragraph 69 inserts a new paragraph 82G(ba). The new function for the Private Health Insurance Administration Council that is inserted into section 82G by new paragraph 82G(ba) enables the Council to obtain data in accordance with the categories of information listed in the Hospital Casemix Protocol (which is to be prescribed) from registered health benefits organizations. The information will be used by the Council for the purposes of modelling, evaluation and research.

70. After paragraph 82G(m):

Paragraph 70 inserts a new paragraph 82G(ma). The new function for the Private Health Insurance Administration Council that is inserted into section 82G by new paragraph 82G(ba) enables the Council to collect and disseminate information about private health insurance for the purpose of enabling consumers of private health insurance products to make an informed choice of product.

71 - 90. Subsection 82PA(2); Subsection 82Q(1) (definition of "affairs"); Paragraph 82R(1)(aa); Subsection 82R(2); Subsection 82W(2); Subsections 82Z(1) and (2); Subsections 82ZA(1) and (4); Section 82ZD; Subsection 82ZE(1); Paragraph 82ZE(1)(a); Subsection 82ZE(2); Subsections 82ZF(1) and (2); Subsections 82ZG(1) and (2); Subsection 82ZK(3); Subsection 82ZN(2); Subsection 82ZP(1) and (3); Paragraph 82ZP(3)(a):

All registered health benefits organizations are to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed. The above paragraphs insert consequential amendments which reflect the removal of this requirement by providing, for example, that the phrase "a health fund" is to be replaced with "the health fund".

Paragraph 77, which amends subsection 82Z(2), and paragraph 88, which amends subsection 82ZP(1), also have the purpose of correcting the structure of the subsections amended.

91. After Part VIB:

Part VIC - Private Health Insurance Complaints Commissioner

Paragraph 91 creates a new Part VIC, which establishes an independent Private Health Insurance Complaints Commissioner.

Division 1 - Preliminary

Interpretation

New subsection 82ZQ(1) inserts definitions of "complainant", "complaint", "Complaints Commissioner", "personal information" and "private health insurance arrangement" for the purposes of new Part VIC.

New subsection 82ZQ(1) defines "private health insurance arrangement" as including an applicable benefits arrangement, a hospital purchaser-provider agreement, a medical purchaser-provider agreement, a supplementary hospital table or any other table, and an arrangement under which a supplementary hospital table or any other table of benefits is offered.

New subsection 82ZQ(2) provides that a reference in Part VIC to a person or body against whom a complaint is made is to be read as a reference to a hospital, day hospital facility, medical practitioner, or registered organization whose conduct or failure to act is the subject of the complaint.

Division 2 - Complaints Commissioner

Private Health Insurance Complaints Commissioner

New section 82ZR creates a Private Health Insurance Complaints Commissioner (the Complaints Commissioner) who will be an incorporated body.

Appointment

New section 82ZRA provides that the Complaints Commissioner will be appointed by the Minister, according to guidelines, on a full-time or part-time basis.

Guidelines

New section 82ZRB allows the Minister to make guidelines relating to the appointment of the Complaints Commissioner and the terms, conditions and period of appointment of the Commissioner.

Functions of the Complaints Commissioner

New section 82ZRC outlines the functions of the Complaints Commissioner. The Commissioner will be able to:

- deal with complaints by contributors, hospitals, day hospitals, medical practitioners and registered health benefits organizations (refer to new section 82ZS);
- conduct investigations on his or her own initiative (see new section 82ZT), or at the request of the Minister (see new section 82ZTA), into the practices and procedures of a registered organization;
- publish aggregate information on complaints made;
- make recommendations to the Department of Human Services and Health on policy matters relating to regulating the private health insurance industry and industry practices;
- promote a knowledge and understanding of his or her functions; and
- perform any functions that are incidental to the above.

Division 3 - Complaints

Who may make a complaint?

New section 82ZS provides that the Complaints Commissioner is empowered to handle complaints made by contributors to a health benefits fund, hospitals, day hospitals, medical practitioners and health benefits organizations; or by another person on behalf of that person or body.

Grounds for complaint

New section 82ZSA restricts the scope of complaints that the Complaints Commissioner can receive to matters which have some connection with a private health insurance arrangement. A private health insurance arrangement is defined under new subsection 82ZQ(1).

Complaints Commissioner may deal with complaints

New section 82ZSB enables the Complaints Commissioner to refer a complaint to a registered health benefits organization if the complainant agrees to this referral. The organization should then investigate and report back to the Complaints Commissioner. If no satisfactory resolution is reached, the Commissioner may then, if the complainant agrees, investigate the complaint.

Commissioner may refer matters to other bodies

New section 82ZSC requires the Complaints Commissioner to refer a matter to another body if the Complaints Commisioner views that the matter is more effectively and conveniently dealt with by that body. The complainant must consent to this referral.

Complaints Commissioner may make recommendations

New section 82ZSD enables the Complaints Commissioner, after receiving a report from a registered organization or after investigating the complaint, to recommend to the registered health benefits organization that a specific course of action be taken in relation to the complaint. The Complaints Commissioner may also recommend that the organization change its rules. Alternatively, the Complaints Commissioner may recommend that a registered organization request that a hospital, day hospital facility or medical practitioner take a specific course of action in relation to the complaint.

Complaints Commissioner must keep complainant informed

New section 82ZSE imposes a duty on the Complaints Commissioner to inform the complainant of investigations, referrals and recommendations made by the Complaints Commissioner. Reasons for such action must be given.

The Complaints Commissioner must also notify the complainant, in writing, of any resulting action taken by a registered health benefits organization.

Conciliation

Under new section 82ZSF, if the complainant is dissatisfied with the referral to the registered health benefits organization, the investigations conducted or the recommendations made by the Complaints Commissioner, new subsection 82ZSF(1) enables the complainant to request that the Commissioner act as conciliator between the complainant and the body against whom the complaint has been made. The Complaints Commissioner has a discretion to assent to this request.

Complaints Commissioner may decide not to investigate

Under new section 82ZSG, the Complaints Commissioner does not have to investigate a complaint if:

- the hospital, day hospital facility, medical practitioner or registered health benefits organization is dealing with; has dealt with; or has not yet had an adequate chance to deal with the complaint;
- the matter is trivial;
- the complaint is vexatious or was not made in good faith;

- the complainant has not taken reasonable steps to settle the complaint; or
- the complainant does not agree to the referral to another body under section 82ZSC.

Under subsection 82ZSG(3), the Commissioner need not take any action on the complaint if 12 months has elapsed since the incident to which the complaint relates.

Under new subsection 82ZSG(5), if the Commissioner decides not to investigate, or not to continue to investigate, a complaint, the complainant must be told of this decision, and the reasons for this decision, in writing.

Division 4 - Complaints Commissioner may conduct investigations

Complaints Commissioner may initiate investigations

New section 82ZT enables the Complaints Commissioner to initiate his or her own investigations into the practices and procedures of a registered health benefits organisation.

Minister may request Complaints Commissioner to conduct investigations

New section 82ZTA enables the Minister to instruct the Complaints Commissioner to conduct an investigation into the practices and procedures of a registered health benefits organization. The Complaints Commissioner must report back to the Minister on the results of such an investigation.

Complaints Commissioner may examine records

New section 82ZTB enables the Complaints Commissioner to access the records and rules of a registered organization when conducting an investigation into the practices and procedures of an organization under new section 82ZT or 82ZTA.

Complaints Commissioner may make recommendations to registered organizations

After investigating a complaint under new sections 82ZT and 82ZTA, new section 82ZTC gives the Complaints Commissioner the power to recommend to a registered organization, hospital, day hospital, or medical practitioner that a specific course of action be taken. The Complaints Commissioner may also recommend that a registered organization change its rules. The registered health benefits organization, hospital, day hospital or medical practitioner may also be requested by the Complaints Commissioner to report back on any action taken on the recommendation.

Protection from civil actions

Where a person has given a statement in good faith as part of an investigation by the Complaints Commissioner, new section 82ZTD provides that no civil action can be brought against that person for any effect which this statement may have.

Division 5 - Provisions relating to the Commissioner

Validity of appointments

New section 82ZU provides that a defect or irregularity in the appointment of the Complaints Commissioner does not invalidate the appointment.

Acting appointments

New section 82ZUA allows an acting Complaints Commissioner to be appointed by the Minister. This provision is based on section 82PC of the National Health Act 1953.

Remuneration and allowances

New section 82ZUB provides that remuneration of the Complaints Commissioner is determined by the Remuneration Tribunal and that any allowances are to be prescribed. This section is based on section 82PE of the National Health Act 1953.

Outside employment

New subsection 82ZUC(1) prohibits the Complaints Commissioner from having any other full-time paid work unless the Minister assents to this in writing. New subsection 82ZUC(2) provides that the Complaints Commissioner cannot engage paid part-time work which the Minister considers will conflict with the Commissioner's functions.

Leave of absence

New section 82ZUD governs the leave which the Complaints Commissioner may take. This section is based on section 82PEA of the National Health Act 1953.

Resignation

New section 82ZUE provides for the method by which the Complaints Commissioner may resign.

Termination of appointment

New subsection 82ZUF(1) specifies that the Minister must terminate the Complaints Commissioner's appointment if the Complaints Commissioner is found to be misbehaving or physically or mentally incapable.

Under new subsection 82ZUF(2) the Minister has the discretion to terminate the Complaints Commissioner's appointment on the grounds of:

- bankruptcy;
- absence from duty without leave for a specified period of time; or

- failure to comply with new section 82ZUC.

Staff

New section 82ZUG gives the Complaints Commissioner the power to employ staff, and determine the terms and conditions under which they will work. New subsection 82ZUG(2) allows the Complaints Commissioner to make arrangements for officers of the Australian Public Service to work for him or her.

Division 6 - Miscellaneous

Minister may issue guidelines

New section 82ZV allows the Minister to issue privacy guidelines. These guidelines will be disallowable instruments.

Application of Division 3 of Part XI of the Audit Act 1901

New subsection 82ZVA(1) applies Division 3 of Part XI of the Audit Act 1901 to the Complaints Commissioner. This is to allow the Auditor-General to audit the Complaints Commissioner.

New subsection 82ZVA(2) provides that the Complaints Commissioner must supply to the Minister an annual report on the operations under new Part VIC. This report shall include summarised information on complaints received, as well as outcomes of actions, referrals, recommendations and investigations.

Victimisation

New section 82ZVB provides for a penalty of six months imprisonment to be imposed on a person who in any way harms or threatens harm to another person because that person makes a complaint under new Part VIC.

Collection of levy

New section 82ZVC provides that a levy, as set up by regulations made under the Private Health Insurance Complaints Levy Act 1994, is to be imposed on registered organizations as a debt due to the Commonwealth 14 days after a day fixed by regulations.

92 - 93. Subsection 140(2); Paragraphs (b), (ba), (bb) and (be) of Schedule 1:

Paragraphs 92 and 93 make consequential amendments that are necessary because all registered health benefits organizations are now to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed.

94. After paragraph (be) of Schedule 1:

Paragraph 94 inserts new paragraphs (bf), (bg), (bh) and (bi) into Schedule 1.

New paragraph (bf) of Schedule 1 imposes a condition of registration on registered health benefits organizations. New paragraph (bf)(i) provides that the organization will provide health cover for a contributor in circumstances where that contributor is admitted in an emergency to a hospital or day hospital facility with which the organization does not have a hospital purchaser-provider agreement.

New paragraph bf(ii) provides that a registered organization will pay a benefit for a contributor's treatment in a hospital or day hospital facility with which the organization has no hospital purchaser-provider agreement.

New paragraph (bg) of Schedule 1 provides that benefits payable to a contributor admitted in an emergency to a hospital or day hospital facility with which the organization does not have a hospital purchaser-provider agreement, are to equal or exceed the average amount of benefits that would have been payable by the organization if that hospital or day hospital facility had been one with which the organization had a hospital purchaser-provider agreement.

New paragraph (bh) of Schedule 1 provides that from a day that is prescribed, or if no day is prescribed, 1 July 1998, an organization does not have to provide in its applicable benefits arrangement for circumstances where a contributor is admitted to a hospital or day hospital facility with which the organization does not have a hospital purchaser-provider agreement.

New paragraph (bi) of Schedule 1 provides that the conditions set out in new paragraphs (bf) and (bg) do not apply in respect of public hospitals.

95. Paragraph (c) of Schedule 1:

Paragraph 95 amends paragraph (c) of Schedule 1. The amendment is a consequential amendment which is necessary because all registered health benefits organizations are now to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed.

96. After paragraph (e) of Schedule 1:

Paragraph 96 inserts new paragraphs (eb) and (ec) into Schedule 1.

New paragraph (eb) of Schedule 1 imposes a condition of registration on registered health benefits organizations which provides that benefits which would be payable in accordance with a basic table of an organization (the basic table amount) are not payable to a contributor for in-hospital treatment unless the basic table amount is the amount of payment that was agreed upon in advance by the organization and a hospital or day hospital facility in a hospital purchaser-provider agreement.

New paragraph (ec) of Schedule 1 provides that new paragraph (eb) does not apply to episodes of hospital treatment in recognised hospitals i.e., public hospitals.

97 - 100. Paragraphs (g), (h), (ha), and (l) of Schedule 1:

All registered health benefits organizations are to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed. The above paragraphs insert consequential amendments which reflect the removal of this requirement by providing that the phrase "a health fund" or "each health benefits fund" is to be replaced with "the health benefits fund".

101. Subparagraph (l)(i) of Schedule 1:

Paragraph 100 amends subparagraph (l)(i) of Schedule 1. The insertion of the phrase "before 1 July 1995" after "conducted" in subparagraph (l)(i) is a consequential amendment that reflects the removal, by these amendments (which commence on 1 July 1995), of the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates.

102 - 103. Subparagraph (l)(iii) of Schedule 1; Paragraph (n) of Schedule 1:

All registered health benefits organizations are to operate single national funds, i.e., the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates, is removed. Paragraphs 102 and 103 insert consequential amendments which reflect the removal of this requirement by providing that the phrase "a health fund" is to be replaced with "the health benefits fund".

Part 2 - Amendments of the Health Insurance Commission Act 1973

This Part amends the Health Insurance Commission Act 1973 as set out below. These amendments are to commence on 1 July 1995.

104. Subsection 8A(1):

Paragraph 104 amends subsection 8A(1). The phrase "in respect of a State or of the Northern Territory" is omitted from subsection 8A(1) to reflect the removal of the requirement that a health benefits organization must register one health fund in every State or Territory in which it operates.

105. After subsection 8A(1):

Paragraph 105 inserts a new subsection 8A(1A). New subsection 8A(1A) is inserted to require Medibank Private to continue to operate in each State and the Northern Territory.

Schedule 3 : Amendments commencing on 1 July 1996

1. Paragraphs (bi) and (ec) of Schedule 1

Paragraph 1 of Schedule 3 omits paragraphs (bi) and (ec) from Schedule 1 of the National Health Act 1953. This means that health benefits organizations are no longer required to pay benefits in accordance with a basic table in respect of admissions to recognised hospitals (i.e. public hospitals) which do not enter into a hospital purchaser-provider agreement.

For the period 1 July 1996 to at least 1 July 1998, all hospitals and day hospital facilities which do not have a hospital purchaser-provider agreement will receive a benefit determined by individual organizations.

Schedule 4 : Amendments commencing on 1 July 1997

1. Subsection 4(1) (paragraph (a) of the definition of "waiting period"):

Paragraph 1 of Schedule 4 omits the reference to a supplementary hospital table from paragraph (a) of the definition of "waiting period". This is a consequential amendment because the definition of "supplementary hospital table" is omitted from subsection 4(1) of the National Health Act 1953. Casemix episodic payments have replaced the payment of benefits according to a supplementary hospital table. Therefore, a supplementary hospital table no longer forms part of the private health insurance arrangements.

2. Subsection 4(1)(definition of "basic private table" or "basic table"):

Paragraph 2 of Schedule 4 omits the definition of "basic private table" or "basic table" from subsection 4(1). The definition of "basic private table" or "basic table" is omitted from subsection 4(1) of the National Health Act 1953, because casemix episodic payments have replaced the payment of benefits according to a basic table. Therefore, the basic table no longer forms part of the private health insurance arrangements.

3. Subsection 4(1) (definitions of "supplementary hospital table"; "type-A professional attention"; "type-B professional attention' and "type-C professional attention"):

Paragraph 3 of Schedule 4 omits the definitions of "supplementary hospital table", "type-A professional attention", "type-B professional attention" and "type-C professional attention" from subsection 4(1) of the National Health Act 1953. The definitions are omitted because casemix episodic payments have replaced the payment of benefits according to a basic or supplementary hospital table. Therefore, basic and supplementary hospital tables no longer form part of the private health insurance arrangements.

4 - 5. Sections 4B, 4C, 4D and 5; Subsection 5A(1):

Paragraph 4 of Schedule 4 omits sections 4B, 4C, 4D and 5 while paragraph 5 amends subsection 5A(1). These consequential amendments are necessary because the definition of "basic private table" or "basic table" is omitted from subsection 4(1) of the National Health Act 1953. Casemix episodic payments have replaced the payment of benefits according to a basic table. Therefore, the basic table no longer forms part of the private health insurance arrangements.

6 - 10. Subsections 73BB(2), (4), (4A), (5), (6) and (11)(definition of "episode duration"):

Paragraphs 6 to 10 of Schedule 4 omit references to basic tables and supplementary hospital tables in the above subsections. These are consequential amendments because the definitions of "basic table" and "supplementary hospital table" are now omitted from subsection 4(1) of the National Health Act 1953. Casemix episodic payments have replaced the payment of benefits according to a supplementary hospital table. Therefore, a basic table and a supplementary hospital table no longer form part of the private health insurance arrangements.

11. Paragraph 73BD(1)(b):

Paragraph 11 of Schedule 4 omits paragraph 73BD(1)(b) and substitutes a new paragraph. These consequential amendments are necessary because the definitions of "basic private table" or "basic table" and "supplementary hospital table" are omitted from subsection 4(1) of the National Health Act 1953. Casemix episodic payments have replaced the payment of benefits according to a basic table and a supplementary hospital table. Therefore, the basic table and supplementary hospital table no longer form part of the private health insurance arrangements.

12. Subsection 82ZQ(1) (paragraphs (d) and (e) of the definition of "private health insurance arrangement")

Paragraph 12 of Schedule 4 omits the words "supplementary hospital table or any other" from subsections 82ZQ(1) (paragraphs (d) and (e) of the definition of "private health insurance arrangement"). These are consequential amendments because the definition of "supplementary hospital table" is omitted from subsection 4(1) of the National Health Act 1953. Casemix episodic payments have replaced the payment of benefits according to a supplementary hospital table. Therefore, a supplementary hospital table no longer forms part of the private health insurance arrangements.

13 - 14. Subparagraphs (bd)(ii) and (bd)(iii) of Schedule 1:

Paragraph 14 of Schedule 4 omits subparagraph (bd)(iii) of Schedule 1. As a result, paragraph 13 of Schedule 4 omits "; and". These consequential amendments are necessary because the definition of "basic private table" or "basic table" is omitted from subsection 4(1) of the National Health Act 1953. Casemix episodic payments have replaced the payment of benefits according to a basic table. Therefore, the basic table no longer forms part of the private health insurance arrangements.

15. Paragraphs (eb) and (f) of Schedule 1:

Paragraph 15 of Schedule 4 omits paragraphs (eb) and (f) of Schedule 1 and substitutes a new paragraph. These consequential amendments are necessary because the definition of "basic private table" or "basic table" is omitted from subsection 4(1) of the National Health Act 1953 and payments must be made in accordance with an applicable benefits arrangement.

16. Paragraph (k) of Schedule 1:

Paragraph 16 of Schedule 4 omits existing paragraph (k) of Schedule 1 and substitutes a new paragraph. This consequential amendment is necessary because the definition of "basic private table" or "basic table" is omitted from subsection 4(1) of the National Health Act 1953. Casemix episodic payments have replaced the payment of benefits according to a basic table. Therefore, the basic table no longer forms part of the private health insurance arrangements.

17 to 25. Paragraph (kb) of Schedule 1; Subparagraph (kc)(i) and (ii) of Schedule 1; Paragraph (la) of Schedule 1; Subparagraph (la)(iv) of Schedule 1; Subparagraph (laa)(i) of Schedule 1; Subparagraphs (laa)(ii) and (iii) of Schedule 1; Subparagraph (laa)(iv) of Schedule 1; and Sub-subparagraph (ld)(i)(A) of Schedule 1:

Paragraphs 17 to 25 amend the above paragraphs, subparagraphs and sub-subparagraph. These consequential amendments are necessary because the definitions of "basic private table" or "basic table" and "supplementary hospital table" are omitted from subsection 4(1) of the National Health Act 1953. Casemix episodic payments have replaced the payment of benefits according to a basic table and a supplementary hospital table.

Therefore, the basic table and supplementary hospital table no longer form part of the private health insurance arrangements.

Printed by Authority by the Commonwealth Government Printer


9 780644 302876