Gold/Silver/Bronze/Basic tiers of private health insurance covering hospital treatment

This fact sheet provided by Day Hospitals Australia is part of a series of five fact sheets covering the following topics as relevant to day hospitals:

- **Second Tier Default Benefits**
- **Gold/Silver/Bronze/Basic tiers of private health insurance covering hospital treatment**
- **Standardisation of clinical categories under private health insurance tiers**
- **Changed powers of the Private Health Insurance Ombudsman**
- **Changes to Prostheses Benefits for Medical Devices**

1 Executive Summary

As at 1 April 2020, each private health insurance policy covering hospital treatment (whether alone, or together with general treatment) must:

- fall within one of the prescribed tiers, being “Gold”, “Silver”, “Bronze”, or “Basic”;
- cover treatments in all clinical categories that are prescribed to be included in that tier, and relevant treatment as included within the scope of each clinical category;
- meet requirements around restricted or unrestricted cover as required for the applicable tier;
- cover associated treatment for complications, and associated unplanned treatment, where they arise from covered treatment; and
- meet additional requirements for naming policies that cover hospital treatments.

During the transition period from 1 April 2019 until 31 March 2020 (**Transition Period**), private health insurance funds are required to comply with these coverage requirements only where the name of the relevant policy contains any one of the of the words “Gold”, “Silver”, “Bronze”, or “Basic”.

Private health insurance funds also must not use the name of any mineral (eg “platinum”) or precious or semi-precious stone (eg “diamond” or “amber”) in the name of any policy from 1 April 2019.

These changes do not regulate the terms of negotiated agreements between hospitals and private health insurance funds.

Day hospitals should do the following:

- Day hospitals should familiarise themselves with and educate relevant staff and medical practitioners practising at the facilities about the new framework around tiers of private health insurance covering hospital treatment. They should be familiar with the categories of clinical treatment that the day hospital provides, and whether such categories are included or excluded, and any requirements around restricted or unrestricted coverage, under each of the four tiers.
- The relevant tiers of private health insurance and clinical categories as required for each tier are provided in the Appendix for quick reference, and are also set out in a fact sheet for the general public as referenced in section 9, **Resources from the Department of Health**.

- Day hospitals should also understand how the standardisation of clinical categories under each tier applies, including groupings of specific Medicare Benefits Schedule (**MBS**) items. This is addressed in more detail in another fact sheet in this series, **Standardisation of clinical categories under private health insurance tiers.**
- Where possible, day hospitals may wish to ensure that their clinical billing systems are set up in a way that identifies coverage requirements where a patient holds an insurance product including the "Gold", "Silver", "Bronze", or "Basic" designation in the name. This allows for identification of a patient's entitlement for coverage for specific MBS items based on the patient's insurance tier.
- Day hospitals must still ensure that they comply with any applicable requirements, eg in relation to eligibility checks, under negotiated agreements with private health insurance funds.
- Day Hospitals should also understand and educate staff about when emergency or unexpected treatment provided during or as a result of covered treatment must also be covered by the patient's private health insurance fund. This includes educating medical practitioners about the need to clearly document in the medical record if and why such treatment is being provided.
- Lastly, day hospitals should ensure that they have processes in place to identify any changes to the treatments referable to clinical categories under the Complying Product Rules.

2 Background

Under the *Private Health Insurance Act 2007* (Cth) (**PHI Act**), private health insurance policies must be compliant with specific requirements as set out in subordinate legislation, including the *Private Health Insurance (Benefit Requirements) Rules 2011* (Cth) (**Benefit Requirements Rules**), and the *Private Health Insurance (Complying Product) Rules 2015* (Cth) (**Complying Product Rules**).

Changes to the framework under the PHI Act through the *Private Health Insurance Legislation Amendment Act 2018* and *Private Health Insurance (Reforms) Amendment Rules 2018* (Cth) (**Amending Rules**) provide for extensive changes in the required coverage, and naming requirements, for policies that cover hospital treatment. These changes are designed to give clarity to consumers about exactly what sort of hospital treatment will be covered under a specific policy, and to enable consumers to compare policies more easily, within and across tiers, and between different health insurance funds.

3 Framework for tiers

For each of the four tiers, "Basic", "Bronze", "Silver", and "Gold", coverage of specific clinical categories is required (see details in the Appendix). Each tier includes the categories contained in the next "lower" tier as well as additional ones.

The list includes a total of 38 categories. Categories that are expected to be particularly relevant for day hospitals include the following:

- "Tonsils, adenoids and grommets";
- "Bone, joint and muscle";
- "Gastrointestinal endoscopy",
- "Chemotherapy, radiotherapy and immunotherapy for cancer";
- "Skin";
- "Dental surgery";

- "Cataracts";
- "Dialysis for chronic kidney failure"; and
- "Assisted reproductive services".

MBS items under clinical categories not exhaustive

As further detailed in the fact sheet **Standardisation of Clinical Categories under Private Health Insurance Tiers**, the list of MBS items set out against each clinical category are not an exhaustive list of treatment that must be covered within the scope of the relevant category.

Only covered treatment is required to be covered during an episode

The FAQ Document clarifies that where a patient decides to seek two types of treatment during the same episode of care, for example having a tonsillectomy and dental surgery done while receiving one general anaesthetic, a private health insurance fund is only required to provide benefits for the treatment that is actually covered. In the given example, if a patient has a Bronze policy (which includes the clinical category of "Tonsils, adenoids and grommets", but not "Dental Surgery"), the insurer would only have to cover the treatment referable to the tonsillectomy.

4 Options for restricted cover for clinical categories

Restricted and unrestricted cover

Coverage requirements provide for two types of cover, restricted and unrestricted.

The terms "restricted cover" and "unrestricted cover" are not defined in the Complying Product Rules or the PHI Act. The Explanatory Statement to the Amending Rules states that "*[r]estricted cover is a term used in the insurance sector generally to describe cover under which the insurer undertakes to pay only the minimum default benefit set out in Schedules 1, 2, 3 and 4 of the Private Health Insurance (Benefit Requirement) Rules.*"

The FAQ Document further clarifies these terms as follows:

> ***What is meant by restricted and unrestricted cover?***
>
> *A policy provides restricted cover for particular hospital treatments if the benefit paid toward the hospital's charge for that treatment is always at a restricted level, even if the service is provided at a hospital contracted to the insurer.*
>
> *Where a policy provides a restricted benefit for particular services, the benefit for the hospital component is generally restricted to the amount required under the* Private Health Insurance (Benefit Requirements) Rules*.*
>
> *If a policy fully covers the hospital charge for the particular hospital treatment when the treatment is provided at a contracted hospital it is not restricted cover. This is the case even if the policy only pays benefits equal to the amounts required in the* Private Health Insurance (Benefit Requirements) Rules *for that treatment at non-contracted hospitals.*

Cover is therefore considered "unrestricted" even if benefits for hospital treatment at non-contracted hospitals are the second tier default benefits as provided for under Schedule 5 of the Benefit Requirement Rules, as discussed in more detail in the fact sheet **Second Tier Default Benefits** in this series.

Types of coverage requirements for each clinical category

In addition, for each combination of tier of private health insurance and clinical category, coverage requirements can take different forms, as provided for under rule 11G and Schedule 4 of the Complying Product Rules. The different types of coverage requirements for clinical categories are:

- Category must be included with unrestricted cover (designated as "✓ " in the table set out in the Appendix);
- Category must be included, but may be offered on a restricted basis (designated as "✓**R**" in the table set out in the Appendix);
- Restricted cover permitted (designated as "**RCP"** in the table set out in the Appendix), meaning that insurers may choose whether they wish to include the category on a restricted basis; and
- No minimum requirement; however if a private health insurance fund chooses to offer it as an additional category, it must be unrestricted (designated by a "blank cell" in the table set out in the Appendix).

Rule 11G further provides the following, which is also visually represented in the table in the Appendix:

- For Basic, Bronze, and Silver tiers, the clinical categories of Rehabilitation, Hospital psychiatric services, and Palliative Care may be offered as restricted cover, at the discretion of the private health insurance fund.
- For Gold tier policies, all categories must be offered on an unrestricted basis.
- For Basic tier policies for clinical categories other than those mentioned above, restricted cover is permitted, meaning that each of those categories may be offered on a restricted basis as an additional category.
- For Bronze and Silver tier policies for categories other than those mentioned above, where coverage is required (as indicated by the "✓"checkmark), it must be unrestricted. Where no coverage is required (unmarked cell), insurers may still choose to supply such cover, but if they do, it must be for unrestricted cover.

5 Required cover for associated treatment for complications and unplanned treatment

Any "Gold", "Silver", "Bronze", or "Basic" policy must cover not only treatment within the scope of cover of a clinical category required for the tier, but also associated treatment for complications, and associated unplanned treatment (Complying Product Rules, rule 11F(2(b)).

By way of explanation, treatment is:

- "associated treatment for complications" if it is provided during an episode of hospital treatment that is within the scope of cover for a clinical category for that policy, and provided for a complication that arises during that episode (Complying Product Rules, rule 11F(7)); and
- "associated unplanned treatment" if it is provided during an episode of hospital treatment that is within the scope of cover for a clinical category for that policy, and is an unplanned treatment provided as part of planned surgery during that episode, and is in the view of the medical practitioner who provides the unplanned treatment medically necessary and urgent (Complying Product Rules, rule 11F(8)).

An example provided in the FAQ document is where a patient urgently requires care for a complication such as cardiac arrhythmia during the admission for a surgical procedure. The attendance by a cardiologist and provision of urgent treatment by way of cardioversion is "associated treatment for complications", and must be covered, even if the policy does not otherwise cover the clinical category of "Heart and vascular system".

For "associated unplanned treatment", the drafting indicates that this is in the clinical discretion of the medical practitioner providing the treatment. The medical practitioner should clearly document in the medical record why

the unplanned treatment was both necessary and urgent under the specific circumstances (including patient characteristics, intraoperative findings, and results of any diagnostic tests, eg pathology and radiographic examinations).

Situations where such associated unplanned treatment may foreseeably arise include where any skin or other cancerous lesion intraoperatively is found to extend further than anticipated, necessitating removal of additional tissue to achieve clear margins, and possibly requiring grafting or other methods as required to achieve wound closure.

Day hospitals may wish to educate medical practitioners about the importance of clearly documenting the need for associated treatment for complications, and associated unplanned treatment, to ensure appropriate reimbursement for both hospital and medical practitioners by private health funds.

It should be noted that “episode” is not defined under the PHI Act or Complying Product Rules, and therefore has its general meaning.

6 Timing for when the changes apply

During the Transition Period

During the Transition Period, private health insurers are not generally required to implement the prescribed private health insurance product tiers and coverage requirements.

However, if a private health insurance fund offers a product covering hospital treatment during the Transition Period, and the name of the product contains any one of the of the words “Gold”, “Silver”, “Bronze”, or “Basic”, such a product must comply with the requirements that apply to a product of the relevant tier after the Transition Period, including the requirement for clinical categories and required treatments within the scope of each category, and coverage for associated unplanned treatment, and treatment for complications.

Some private health insurance funds are already implementing the tiers.

In addition, from 1 April 2019, private health insurers must no longer use any words for a metal (eg “platinum”) or any gemstone or semi-precious stone (eg “diamond” or “amber”) in the name of any health insurance product, whether they cover hospital treatment, general treatment, or both.

From 1 April 2020

Private Health Insurers must only offer products for hospital cover containing one of the tiers in their name, falling into the relevant tier, and covering everything that is required under that tier, from 1 April 2020 onwards. They must also provide coverage for associated unplanned treatment and treatment for complications arising from an episode of treatment that is covered under the policy as detailed above, part 5, **Required cover for associated treatment for complications and unplanned treatment**.

Also, from that date, private health insurers must only use the word “plus” (or “+”) in the name of a policy that covers hospital treatment only, or hospital treatment and extras treatment, but not for a policy that covers general treatment only. Furthermore, where “plus” (or “+”) is used in the name of a policy, the policy of that name must cover hospital treatment of a clinical category or categories that is not otherwise required to be included in the relevant tier.

7 Accident and ambulance cover do not allow for “+” designation

Private health insurance funds are still allowed to provide accident cover for treatment of injuries sustained in an accident where this treatment falls within a clinical category that would not otherwise be covered (Rule 11F(4) of the Complying Product Rules). They may also provide ambulance cover, and may include reference to this on the

Standard Information Statement (SIS) and Private Health Information Statement. However, as neither of the two are designated clinical categories, including accident and/or ambulance cover in a product does not allow for use of “plus” or “+” in the policy name.

8 Contacting the PHIO

The Private Health Insurance Ombudsman (**PHIO**) has an important mediation role in resolving issues between private hospitals and health insurance funds, particularly in relation to issues that may impact the rights of consumers. This would include questions where policies may not be compliant with requirements under the PHI Act and the Benefit Requirement Rules or Complying Product Rules. For more information about the role and powers of the PHIO, also see the Factsheet **Changed Powers of the Private Health Insurance Ombudsman** in this series.

- Contact details for the PHIO and further resources can be found at:

  http://www.ombudsman.gov.au/How-we-can-help/private-health-insurance

- The PHIO’s mediation guidelines are available at:

  https://www.ombudsman.gov.au/__data/assets/pdf_file/0030/29847/phiomediationguidelinesv1- 2.pdf

9 Resources from the Department of Health

Relevant for day hospitals and other healthcare providers

- Department of Health FAQ Compilation in relation *to Private Health Insurance (Reforms) Amendment Rules 2018* (Cth). These FAQs should be read in conjunction with the Amending Rules, and the Explanatory Statement to the Amending Rules. Gold/Silver/Bronze/Basic tiers are addressed on pages 1-9.
  - Department of Health, *Private Health Insurance (Reforms) Amendment Rules 2018 Frequently Asked Questions (FAQs)*, available at:

    http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reform-rules-2018

For the general public

- The Department of Health has compiled a short (two pages) fact sheet on the clinical categories. The fact sheet includes a table indicating the clinical categories that must be covered for each tier.
  - Australian Government, *Gold, Silver, Bronze, Basic Product Tiers*; available at:

    https://beta.health.gov.au/resources/publications/private-health-insurance-reforms-gold-silver-bronze-basic-product-tiers-fact-sheet
- The Department of Health has compiled a short (two pages) general fact sheet on the changes to private health insurance regulation. This fact sheet is also available in community languages other than English (simplified Chinese, traditional Chinese, Arabic, Vietnamese and Korean).
  - Australian Government, *Making private health insurance simpler for everyone*, available at:

    https://beta.health.gov.au/resources/publications/making-private-health-insurance-simpler-for everyone-fact-sheet

Appendix

The clinical categories as required for each tier of private health insurance policies are set out in **Schedule 4 – Product tiers and clinical categories** of the Complying Product Rules. For quick reference, Schedule 4 as in force at 1 April 2019 is set out below.

Schedule 4 – Product tiers and clinical categories

For the definition of ***gold policy***, ***silver policy***, ***bronze policy*** and ***basic policy*** in rule 4, and for rule 11H, the following table sets out the clinical categories that are indicated for policies of each product tier.

Clinical category	Basic	Bronze	Silver	Gold
Rehabilitation	✓R	✓R	✓R	✓
Hospital psychiatric services	✓R	✓R	✓R	✓
Palliative care	✓R	✓R	✓R	✓
Brain and nervous system	RCP	✓	✓	✓
Eye (not cataracts)	RCP	✓	✓	✓
Ear, nose and throat	RCP	✓	✓	✓
Tonsils, adenoids and grommets	RCP	✓	✓	✓
Bone, joint and muscle	RCP	✓	✓	✓
Joint reconstructions	RCP	✓	✓	✓
Kidney and bladder	RCP	✓	✓	✓
Male reproductive system	RCP	✓	✓	✓
Digestive system	RCP	✓	✓	✓
Hernia and appendix	RCP	✓	✓	✓
Gastrointestinal endoscopy	RCP	✓	✓	✓
Gynaecology	RCP	✓	✓	✓
Miscarriage and termination of pregnancy	RCP	✓	✓	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	RCP	✓	✓	✓
Pain management	RCP	✓	✓	✓
Skin	RCP	✓	✓	✓
Breast surgery (medically necessary)	RCP	✓	✓	✓
Diabetes management (excluding insulin pumps)	RCP	✓	✓	✓
Heart and vascular system	RCP		✓	✓
Lung and chest	RCP		✓	✓
Blood	RCP		✓	✓
Back, neck and spine	RCP		✓	✓
Plastic and reconstructive surgery (medically necessary)	RCP		✓	✓
Dental surgery	RCP		✓	✓
Podiatric surgery (provided by a registered podiatric surgeon)	RCP		✓	✓
Implantation of hearing devices	RCP		✓	✓
Cataracts	RCP			✓

Clinical category	Basic	Bronze	Silver	Gold
Joint replacements	**RCP**			✓
Dialysis for chronic kidney failure	**RCP**			✓
Pregnancy and birth	**RCP**			✓
Assisted reproductive services	**RCP**			✓
Weight loss surgery	**RCP**			✓
Insulin pumps	**RCP**			✓
Pain management with device	**RCP**			✓
Sleep studies	**RCP**			✓

✓	Indicates the clinical category is a minimum requirement of the product tier. The clinical category must be covered on an unrestricted basis.
✓**R**	Indicates the clinical category is a minimum requirement of the product tier. The clinical category may be offered on a restricted cover basis in Basic, Bronze and Silver product tiers only.
RCP	Restricted cover permitted: indicates the clinical category is not a minimum requirement of the product tier. Insurers may choose to offer these as additional clinical categories on a restricted or unrestricted basis.
	A blank cell indicates that the clinical category is not a minimum requirement of the product tier. Insurers may choose to offer these as additional clinical categories; however it must be on an unrestricted basis.

Contact

General information about Day Hospitals Australia (**DHA**), including about membership, can be found at https://www.dayhospitalsaustralia.net.au/.

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