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BILLS DIGEST

18 September 2007, no. 49, 2007–08, ISSN 1328-8091

Health Legislation Amendment Bill 2007

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Health Legislation Amendment Bill 2007

Date introduced: 13 September 2007

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Various dates (See Explanatory Memorandum)

Links: The relevant links to the Bill, Explanatory Memorandum and second reading speech can be accessed via BillsNet, which is at http://www.aph.gov.au/bills/. When Bills have been passed they can be found at ComLaw, which is at http://www.comlaw.gov.au/.

Purpose

The purpose of this Bill is to make a number of amendments to two pieces of health legislation in order to correct inadvertent or unintended consequences of these Acts. Amendments are proposed for the *Private Health Insurance Act 2007* (PHIA) and the *National Health Act 1953* (NHA).

Background

During 2007 the government implemented major changes to two key health policy areas: private health insurance and pharmaceutical benefits arrangements. Further details of the legislative changes are outlined in the relevant Bills Digests.[1]

Broadly, the reforms for private health insurance established a new regulatory regime for private health insurers, while the reforms affecting pharmaceutical benefits introduced major structural changes to the pricing of medicines subsidised under the Pharmaceutical Benefits Scheme (PBS).

These reforms were undertaken after consultation with stakeholders and generated considerable public interest. Both pieces of legislation were referred to Senate Committee Inquiries.

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1 The relevant digests are: Luke Buckmaster and Amanda Biggs, Private Health Insurance Bill 2007, *Bills Digest*, no. 81, Parliamentary Library, 2007; and Luke Buckmaster, Diane Spooner, National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2007, *Bills Digest* no. 169, Parliamentary Library, 2007.

This Bill proposes to correct or rectify some unintended consequences of the original legislation.

Significant amendments are discussed below.

Private Health Insurance amendments

The Private Health Insurance Bill 2006 and six related Bills were introduced into the House of Representatives in December 2006; subsequently they were passed (with amendments) by the Senate on 23 March 2007.

This suite of Bills introduced a range of reforms to private health insurance arrangements that included allowing for private health insurers to offer a wider range of products, standardised health insurance products, changes to Lifetime Health Cover, changes to prudential arrangements and changes to the role of the regulator the Private Health Insurance Administration Council (PHIAC). In addition various transitional arrangements were introduced.

The reforms, especially Broader Health Cover, were generally supported, although some concerns were raised during the Senate Inquiry.

Under the new arrangements emphasis on regulation shifted from health funds to regulation of health insurance products.

This Bill proposes amendments to one of the issues considered by the Senate Committee: health insurance arrangements affecting overseas visitors. This is discussed further below.

Overseas visitors

The private health insurance reforms introduced changes to health insurance arrangements for overseas visitors such as tourists, 457 visa holders, or overseas students (special provisions apply to students and some temporary visa holders). From 1 July 2008 overseas visitors' health cover will become a general insurance product; that is, general insurers and private health funds can offer this product, which will not be subject to the complying health insurance product arrangements established by the PHIA. Community rating arrangements will cease to apply to overseas visitors' health cover products from this date.

Under the PHIA private health insurers who offer complying health insurance products, are bound by community rating requirements which requires them to offer these products based on community rating principles; that is, without discrimination. Health cover cannot be refused on the basis of age profile, medical history or other risk factors.

General insurers, on the other hand, are not subject to the requirement of the community rating arrangements; they operate in a risk rating environment where they can charge higher premiums (or refuse cover altogether) based on a person's risk profile.

It was argued in a submission to the Senate Inquiry, that community rating requirements when applied to overseas visitors' health insurance may place an unfair burden on private health funds. This is because private health funds are required to accept risks that their competitors in this market, the general insurers, can refuse. Further, general insurers can offer discounts to younger policy holders based on their better risk profiles, shifting higher risk policy holders to private health insurers.[2]

The Bill proposes to remove the requirement that health funds who offer overseas visitors' health cover during the transition period (1 April 2007 to 30 June 2008) must offer it as a 'complying health insurance product'. Penalties for not offering this as a complying health insurance product will also be removed, retrospective to 1 April 2007.

Since 1 April 2007 special provisions to encourage private health insurers to offer health insurance products to overseas students and some other visa holders, under the regulatory authority of the Australian Prudential Regulatory Authority (APRA), have applied. This Bill proposes a transitional provision to allow insurers until 1 July 2008 to comply with these provisions.

This Bill also proposes that from 1 July 2008 overseas visitors' health cover offered by private health funds will be regulated as a 'health related business' under the authority of the PHIAC. In parallel arrangements health cover offered by general insurance funds will be regulated by APRA.

One possible effect of these proposed amendments is that holders of 457 visas may face higher health insurance costs as a result of the removal of the complying health product provisions. Concern over health insurance costs for temporary visa holders was raised in a recent Joint Standing Committee on Migration report.[3]

Pharmaceutical Benefits Scheme amendments

The PBS was established in 1948 to provide free 'life saving and disease preventing drugs'. The PBS has since evolved with around 680 listed drugs. In 2005-06 168 million PBS prescriptions were dispensed. An estimated 72 per cent of all prescriptions dispensed in Australia are subsidised under the PBS. Total Commonwealth expenditure for the PBS

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2. IMAN International, 'Submission to the Senate Community Affairs Committee Inquiry into Private Health Insurance Bill 2006 [provisions] and related Bills', p. 4, (IMAN International has been involved in health insurance and repatriation insurance since 1981, and manages the overseas visitor policy on behalf of Australian Health Management).
3. Joint Standing Committee on Migration, *Temporary visas…permanent benefits: ensuring the effectiveness, fairness and integrity of the temporary business visa program*, JSCM, Canberra, 2007, p. 45.

in 2005-06 was $6.2 billion. PBS medicines attract a co-payment of up to $30.70 for general patients or $4.90 for concession card holders.[4]

In May 2007 a Bill amending the pharmaceutical provisions of the *National Health Act 1953* (NHA) was introduced into the House of Representatives; subsequently the Bill was passed by the Senate on 20 June 2007 and came into effect on 1 August 2007.

The legislation introduced significant structural changes to the pricing of medicines subsidised under the PBS, and was the subject of a Senate Committee Inquiry. The main components of the legislation included the introduction of two 'formularies' for subsidised medicines: F1 for single brand medicines and F2 for multiple brand medicines. Different pricing rules were introduced to apply to each formulary.[5]

The amendments proposed in this Bill aim to clarify and correct provisions in this Bill that affect the pharmaceutical benefits around pharmacists supplying substituted brands of prescribed medicines, repeats of medicines and early supply of medicines.

Substitution arrangements

Under brand substitution arrangements, pharmacists are allowed to substitute to the lowest priced approved bioequivalent generic product, with the permission of the patient and provided the prescriber has not directed otherwise on the prescription. The Government subsidises only to the lowest priced drug in the defined subgroup and consumers pay any difference in price in addition to the usual co-payment. Classes of drugs covered by brand substitution include H2 receptor antagonists and ACE inhibitors.[6]

The Bill proposes introducing a new definition, 'Schedule equivalent', to describe those medicines supplied under brand substitution arrangements. The Bill proposes that only those medicines that are stated to be 'equivalent' in the Schedule of Pharmaceutical Benefits, are eligible for pharmaceutical benefits.

The Bill clarifies that a prescriber does not need to specify the exact brand of medicine when writing the prescription; a prescription will be valid even if the brand is not specified, although a listed drug and its dosage/form must be specified.

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4 Senate Standing Committee on Community Affairs, '*National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2007 [Provisions]: Report*', SSCCA, Canberra, 2007, p.4.

5. Formularies in medicine are listings of prescription medicines for approved use.

6. H2 receptor antagonists are used in the treatment of gastro-oesophageal reflux disease; ACE inhibitors in the treatment of high blood pressure.

The Bill further proposes restricting substitution arrangements to only those medicines specified in the Schedule, so that pharmacy-prepared medicines do not qualify as substitutes.

Repeats

The Bill proposes applying permissible repeat prescription arrangements to Schedule equivalent medicines. Under PBS arrangements a prescription can specify a number of repeats, so that the patient does not need to return to their doctor to obtain a new prescription every time they complete a course of medicine. The maximum number of repeats for a subsidised medicine is specified in the Schedule.

The proposed amendments prevent the number of permissible repeats being exceeded by prescribing more than one Schedule equivalent medicine in a prescription.

Early supply provisions

Under PBS arrangements, when a patient has 'repeat' prescriptions for a PBS medicine, normally they cannot obtain the repeat script until 20 days after the supply of the original prescription. This is designed to prevent 'stockpiling' of medicines. However, in special circumstances the patient can obtain the script early (or immediately) under the 'immediate supply' provisions of the PBS, for example if the original medication is lost or damaged. These early supply prescriptions do not count towards the PBS Safety Net.

Prior to the implementation of the new legislation in August 2007 pharmacists could substitute an equivalent brand under the early supply arrangements. However, the reforms introduced in August 2007 inadvertently narrowed the definition under the early supply provision, so that pharmacists could no longer substitute between different brands. This Bill proposes allowing the substitution of different brands under the early supply arrangements, provided the brands are described as equivalent in the Schedule.

Financial implications

No financial implications.

Main provisions

Schedule 1 -- Private Health Insurance Act 2007 (PHIA)

Section 84-1 of the Act is the enforcement part of the Act: it makes it an offence to advertise a product, or to offer a person insurance under a policy, or to insure a person under a policy that is a non-complying policy. Section 63-10 of the PHIA prescribes the

elements of a 'complying health insurance policy'[7]—private health insurers who make health insurance products available must meet certain obligations to people insured or seeking to be insured under the products.

The current wording of Section 84-1 is making its operation unnecessarily broad in its capture, resulting in penalties for certain insurers who are offering some types of insurance products. For example, general insurers offering accident or disability insurance or private insurers offering overseas students' health cover.[8]

The amendments proposed under Schedule 1 are technical in nature and aim to cure the operational defects in Section 84-1 by narrowing its operational scope and reach.

Item 1

Proposed 84-1(1)(b) makes Section 84-1 only apply to a **'health insurance business'** as defined in Division 121 of the PHI Act.

Item 3

Proposed 84-1(1)(d) clarifies that the Section 84-1 offence does not apply if the 'health insurance business' is not of a kind specified in the Private Health Insurance (Complying Product) Rules.

Section 63-1 of the PHIA requires that a private health insurer only makes available as part of its health insurance business, insurance in the form of complying health products, unless the business is one that is specified as being excluded in the Complying Product Rules. The Explanatory Memorandum points out that while 'there are no excluding

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7 These elements are:

(a) the community rating requirements – this means that the product is made available in a way that does not discriminate against people ; and

(b) the coverage requirements in Division 69; and

(c) if the policy covers hospital treatment—the benefit requirements in Division 72; and

(d) the waiting period requirements in Division 75; and

(e) the portability requirements in Division 78; and

(f) the quality assurance requirements in Division 81; and

(g) any requirements set out in the Private Health Insurance (Complying Product) Rules.

8 Hon. Tony Abbott, 'Health Legislation Amendment Bill 2007: Second reading speech,' House of Representatives, *Hansard,* 13 September 2007, p. 1.

Complying Product Rules made for the purpose of section 63-1, **proposed 84-1(1)(d)** is designed to better align the offence provision with the structure of the PHI Act'.[9]

Item 4

Division 126 of the PHIA deals with the registration rules of private health insurance companies. **Proposed subsection 126-20(4)** of the PHI Act requires the PHIAC to refuse an application for registration as a private health insurer if the rules of the applicant permit improper discrimination in relation to the applicant's complying health insurance policies.

As noted in footnote 7, a key element of a 'complying health insurance policy' is the principle of community rating. **Proposed subsection 126-20(4)** gives operational relevance to this principle.

Part 2 transitional provisions

Item 5 is a transitional provision providing an exemption from sections 63-1 and 84-1 from 1 April 2007 until 30 June 2008. The retrospective and prospective protection applies to private health insurers and insured overseas visitors, in relation to overseas visitor health cover which has been offered by private health insurers in the transitional period under a policy would not meet the requirements of a complying health insurance policy.

Item 6

From the date of the commencement of this item until 30 June 2008, rule 18 of Health Insurance Business Rules applies to overseas student health cover and specified temporary visa holder cover which is provided by private health insurers.

This is designed to allow private health insurers time to adjust to the regulatory system of the Australian Prudential Regulatory Authority (APRA) and the requirements under the Financial Services Reform legislation.

Schedule 2 -- Pharmaceutical Benefits

National Health Act 1953 **(NHA)**

Basically, the amendments proposed by items 2-11 all relate to ensuring that the restriction on the maximum number of permissible prescription repeats cannot be circumvented by various means.

Item 2

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9 Explanatory Memorandum, p. 3.

Proposed subsection 84(1)(1B): where a prescription that directs a repeated supply of a particular pharmaceutical benefit and a pharmacist supplies a substitute benefit as permitted under 103(2A) of the NHA, that substitute is taken to be a repeated supply of that benefit.

Item 3

Proposed subsection 84AAA(1)(a) is designed to prevent the provisions relating to the early supply of a pharmaceutical benefit being circumvented by asking for either the supply of another brand, or an equivalent pharmaceutical benefit.

Items 6 and 7

Proposed subsection 88(1AA) and (1B)/subsection 88(1D)

In order to require that a particular pharmaceutical benefit be provided the prescriber needs to specify the listed drug, the form, the manner of administration and the brand. However, a prescription will be taken to validly direct the supply of a pharmaceutical benefit as long as it lists the drug and a form of the drug, regardless of its failure to specify a brand name or manner of administration.

Items 8 and 4

Proposed paragraphs **88(8)(a) and (b)** provide that where two benefits are Schedule equivalent (as defined by **proposed 84AJ**) or are listed brands of the same pharmaceutical item, the prescription is taken to direct the repeated supply of the first benefit.

Item 10

Proposed 103(2A) will enable the substitution of different pharmaceutical benefits as long as they satisfy the other requirements in subsection 103(2A) including that the Schedule of Pharmaceutical Benefits states that they are equivalent. Currently the operation of this section is narrower, permitting substitution only if they are the same pharmaceutical brand.

Concluding comments

The amendments proposed in this Bill clarify or correct some provisions contained in the *Private Health Insurance Act 2007* and the *National Health Act 1953* that resulted in some unintended consequences.

The amendments relating to private health insurance will clarify when penalties for insurers can be levied, change arrangements for health insurance cover for overseas visitors, and clarify regulatory arrangements.

The amendments relating to pharmaceutical benefits introduce Schedule equivalent definition, and propose to prevent circumvention of supply arrangements relating to repeat prescriptions and brand substitution.

Members, Senators and Parliamentary staff can obtain further information from the Parliamentary Library on (02) 6277 2514.