EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health and Ageing

Private Health Insurance Act 2007

Private Health Insurance (Risk Equalisation Policy) Rules 2025

Section 333-20 of the *Private Health Insurance Act 2007* (the Act) provides that the Minister may make Private Health Insurance (Risk Equalisation Policy) Rules providing for matters required or permitted by Part 6-7 of the Act, or necessary or convenient in order to carry out or give effect to Part 6-7 of the Act.

The *Private Health Insurance (Risk Equalisation Policy) Rules 2025* (the Rules) will commence on 30 September 2025 and revoke and replace the *Private Health Insurance (Risk Equalisation Policy) Rules 2015* (the Previous Rules).

The Rules differ from the Previous Rules by updating definitions for 'age based pool or ABP', 'Business Rules', 'designated threshold', 'eligible benefit', 'gross benefit', 'hospital policy', 'quarter', 'Risk Equalisation Administration Rules', 'single equivalent unit' and 'state'. The Rules also include minor updates that do not alter the intent of the Rules.

Consultation

Public consultation was undertaken from 13 January 2025 to 31 March 2025 on the drafting of these rules. The consultation was promoted through the department's weekly communication to industry participants, including all private health insurers and industry peak bodies.

As part of the consultation, it was proposed that the Previous Rules remained fit for purpose and should be replaced substantially in the same form. In the consultation paper the department provided details of proposed minor amendments to the Previous Rules, sought to understand whether the Previous Rules are considered fit for purpose by those who rely on them, and sought feedback on the proposed amendments.

Three submissions were received in response to the consultation, all supportive of the Previous Rules being remade with the proposed minor amendments.

Additional consultation occurred directly with the financial regulator (APRA), the Office of Impact Assessment and the Private Health Insurance Ombudsman. All agencies consulted supported the remaking of the Rules with the proposed minor amendments.

Regulation Impact Statement

The Office of Best Practice Regulation has advised that no Regulatory Impact Statement is required.

Details of the Rules are set out in the Attachment.

The Rules are a legislative instrument for the purposes of the *Legislative Instruments Act 2003*.

Authority: Section 333-20 of the *Private Health Insurance Act 2007*

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ATTACHMENT

DETAILS OF THE *PRIVATE HEALTH INSURANCE (RISK EQUALISATION POLICY) RULES 2025*

PART 1 - Preliminary

1. Name

Rule 1 provides that the title of the Rules is the Private Health Insurance (Risk Equalisation Policy) Rules 2025.

2. Commencement

Rule 2 provides for the Rules to commence on 30 September 2025.

3. Authority

Rule 3 provides that the instrument is made under the *Private Health Insurance Act 2007*.

4. Definitions

Rule 4 provides the meaning of key words and phrases in the Rules.

5. Schedules

Rule 5 provides that each instrument specified in a Schedule to the instrument is amended or repealed as set out in the applicable items in the Schedule.

6. Single equivalent unit

Rule 6 provides that if a policy falls into one of the categories of policy specified in rule 6 the single equivalent unit for the policy is the number shown next to the category in that rule.

7. Eligible Benefits

Rule 7 provides that an eligible benefit means a benefit paid by an insurer under a policy for any of the following:

(a) the following general treatment, where provided as part of a chronic disease management program:
  (i) the planning and coordination services described in paragraphs (b) and (c) of the definition of chronic disease management program in the Business Rules; and
  (ii) an allied health service;
(b) hospital-substitute treatment;
(c) hospital treatment, other than treatment provided as part of a chronic disease management program, or a program of a similar type in respect of a person with a chronic disease, except as mentioned in paragraph (d); and
(d) the following hospital treatment, where provided as part of a chronic disease management program that is intended to reduce complications in a person with a diagnosed chronic disease:
  (i) the planning and coordination services described in paragraphs (b) and (c) of the definition of chronic disease management program in the Business Rules; and
  (ii) an allied health service.

Subrule 7 (2) provides that the phrases allied health service, chronic disease, chronic disease management program and risk factors for chronic disease have the same meaning as in the Business Rules.

Subrule 7 (3) provides, for the avoidance of doubt, that benefits not covered by paragraph 7 (1) (a) and (d) include benefits paid for any other treatment as part of a chronic disease management program including, but not limited to, diagnosis of chronic disease or the identification of risk factors.

PART 2 – Calculation of levy

8. Purpose of this Part

Rule 8 states that Part 2 of the Rules provides the method for working out the amount to be paid, for crediting to the Special Account, by insurers as risk equalisation levy.

9. Matters to be taken into account

Subrule 9 (1) provides that matters mentioned in Rule 9 are to be taken into account on a State-by-State basis consistently with the organisation of information presented for the quarter by the insurer in its quarterly return for a health benefits fund for a State.

Subrule 9 (2) provides for the matters that must be considered when working out the amount of levy for each health benefit fund of an insurer, for a quarter. These matters include, for example, the age of each insured person in respect of whom an eligible benefit is paid in that quarter, the mean single equivalent units (SEUs) in the quarter, the amount of eligible benefit paid in the quarter and in the preceding three quarters, and any adjustment amount.

Subrule 9 (3) provides that to work out the amount of levy in respect of a current quarter, the amount calculated using the formula in rule 9 (4) is first to be notionally allocated to the age based pool (ABP). Then, if the amount of gross benefit not notionally allocated to the ABP in accordance with subrule (4) or subrule 7 (4) of the old rules as appropriate, the current and preceding three quarters is greater than the designated threshold, a second amount is to be notionally allocated to the High Cost Claimants Pool (HCCP).

Subrule 9 (4) provides for the formula used when calculating the amount to be notionally allocated to the ABP in a quarter.

Subrule 9 (5) provides for the age cohorts which are set out in the table to this subrule.

Subrule 9 (6) provides that where an insured person receives treatment over a number of days such that the insured person falls within more than one age cohort, then the amount to be notionally allocated to the ABP must be allocated proportionately in accordance with the number of days during which the insured person was in each age cohort.

Subrule 9 (7) provides that an amount is to be notionally allocated to the HCCP for a current quarter in respect of an insured person if:

(a) an amount has been notionally allocated to the ABP pursuant to subrule (4); and

(b) the total gross benefit for the current and the immediately preceding 3 quarters less the amount notionally allocated to the ABP under subrule (4), or subrule 7 (4) of the old rules, as appropriate, in the current and preceding 3 quarters exceeds the designated threshold.

Subrule 9 (8) provides the formula to use when calculating the amount to be notionally allocated to the HCCP.

Subrule 9 (9) provides the formula for calculating the total benefit paid into the HCCP under Subrule 9 (8). This amount cannot exceed 82% of the total benefit paid.

Subrule 9 (10) provides that the designated threshold for an insured person is $50,000.

10. Payments by former insurer

Rule 10 provides that if an insurer has paid an amount of eligible benefit in respect to a policyholder and the policyholder moves to a new insurer then the amount of eligible benefit continues to be treated as a payment by the former insurer.

11. Payments where a health benefits fund is transferred

Subrule 11 (1) provides that where a health benefits fund of an insurer is transferred to another health benefits fund (whether or not also a new insurer) then the eligible benefit paid is to be treated as an eligible benefit paid by the receiving health benefits fund.

Subrule 11 (2) provides that if an insurer had paid an amount of levy into the Fund and if the health benefits fund is transferred to another health benefits fund (whether or not also a new insurer) then the amount of levy already paid into the Fund is to be treated as a levy payment by the receiving health benefits fund.

12. Effect of unpaid premiums

Rule 12 provides that if a policyholder has not paid their premiums for a period longer than 2 months after the end of the period for which premiums were last paid, and the insurer has given written notice to the person in whose name the policy is held that the policy is no longer in operation, a single equivalent unit is not to be taken into account for that terminated policy. If the insurer's rules allow for a longer period than 2 months, then the longer period applies.

13. Method of working out

Subrule 13 (1) provides the method for working out the amount of levy (if any) for each health benefits fund of an insurer for a particular quarter in respect of a State.

Subrule 13 (1) (a) provides that, first, for each fund, the total amount of the eligible benefits notionally allocated for the quarter in that State to the ABP and HCCP is calculated and added together. For the total amount for the ABP, see subrule 9 (4) of the Rules, and for the total amount for the HCCP, see subrule 9 (7), or, if applicable, subrule 9 (9) of the Rules.

Subrule 13 (1) (b) provides that, second, the totals from (a) for each fund are summed to obtain a total for the State.

Subrule 13 (1) (c) provides that, third, the total of the average number of SEUs in that State for the quarter for all funds is calculated by determining under subrule 9 (2)(b) of the Rules

the mean number of SEUs for each fund in the State, and adding these numbers together. This gives the paragraph (c) amount.

Subrule 13 (1) (d) provides that, fourth, the paragraph (b) amount is divided by the paragraph (c) amount. This calculates the average amount payable for each SEU.

Subrule 13 (1) (e) provides that, fifth, multiply the paragraph (d) amount by the paragraph (c)(i) amount. This is to obtain the total amount that would have been payable by the insurer in respect of the fund if the SEUs determined under subrule 9 (2) (b) for the fund had each been entitled to the amount calculated under subparagraph (d).

Subrule 13 (1) (f) provides that, sixth, calculate the difference between the paragraph (e) amount and the paragraph (a) amount.

Subrule 13 (2) provides that where an adjustment amount has been determined under Part 4 to be taken into account in a particular quarter, the amount must be taken into account to increase or decrease, as the case requires, the amount that otherwise would be calculated under this rule.

Subrule 13 (3) provides that if an insurer fails to provide APRA with information required under the Risk Equalisation Administration Rules that is necessary to enable APRA to carry out the calculation referred to in this rule for a quarter, APRA must carry out the calculation using the information last provided by the insurer:

(a) to APRA for the relevant quarter and State; or

(b) if the insurer has not provided a quarterly return to APRA, the last return the insurer provided to the Council in accordance with rule 6 of the *Risk Equalisation Administration Rules 2007* as in force on 30 June 2015, for the relevant quarter and State.

14. Working our rate of levy

Subrule 14 (1) provides, subject to subrule 14 (2), that if the amount calculated under paragraph 13 (1) (a) for an insurer is less than the amount calculated under subrule 13 (1) (e) after taking into account any adjustment amount, then the rate of levy imposed on an insurer on a risk equalisation day must be determined, for the quarter concerned, by APRA under the Levy Act, to be the amount equal to the difference.

Subrule 14 (2) provides that if an insurer has more than one health benefits fund in one or more States then the rate of levy for that insurer is determined by adding the amount of levy worked out for each of those funds, less any amount that is to be debited from the Special Account for payment to the insurer in respect of a health benefits fund as determined in accordance with Part 3.

PART 3 – Debits from the Special Account

15. Purpose of this Part

Rule 15 states that for subsection 318-10 (2) of the *Private Health Insurance Act 2007* this rule specifies:

(a) the circumstances in which an insurer is to be paid an amount debited from the Special Account; and

(b) the method for working out the amount to be debited from the Special Account for payment to the insurer.

16. Matters to be taken into account in working out amounts to be paid to insurers

Subrule 16 (1) provides that the same matters are to be taken into account in working out the amount to be debited from the Special Account for payment to an insurer, for a particular quarter and in respect of a particular State, as are to be taken into account under Part 2 for working out amounts to be paid by an insurer as levy, for crediting to the Special Account.

Subrule 16 (2) provides that rule 12 had the same application to this rule as it has to rule 9.

17. Method for working out amounts to be paid to insurers

Rule 17 provides that the same method is to be applied in working out the amount (if any) to be debited from the Special Account for payment to an insurer in respect of a particular State as is to be applied under rule 13 in working out the amount of levy (if any) to be determined for an insurer.

18. Circumstances in which an insurer is to be paid an amount and amount of payment

Subrule 18 (1) provides, subject to subrule 18 (2), in circumstances where the amount calculated under paragraph 13 (1) (a) for an insurer is more than the amount calculated under paragraph 13 (1) (e), after taking into account any adjustment amount, APRA must determine that an amount equal to the difference is the appropriate amount to be debited from the Special Account for payment to the insurer for the quarter concerned.

Subrule 18 (2) provides that if an insurer has more than one health benefits fund in one or more States then the amount to be debited from the Special Account for payment to that insurer is to be determined by offsetting any amount of levy worked out in respect of each of those funds as determined in accordance with Part 2.

19. Manner and time of payment

Subrule 19 (1) provides, subject to subrule 19 (2), APRA must debit from the Special Account an amount worked out in accordance with rule 18 and pay that amount to an insurer, and must do so without unnecessary delay.

Subrule 19 (2) provides that if an insurer has not paid the amount of levy (outstanding levy) imposed under the Levy Act within 14 days after the risk equalisation levy day, APRA must make an instalment payment to all insurers to which payment is due, by paying an amount proportional to the levies received for the quarter and the total amount due to each insurer.

Subrule 19 (3) provides that when any part of the outstanding levy is paid, APRA must make further instalment payments in the next quarter after the amount is received, proportionately to the amount due to the relevant insurers.

Subrule 19 (4) provides that where non-levy is credited to the Special Account APRA may debit from the Special Account amounts up to that amount of non-levy to insurers, but such payments must be made simultaneously to all insurers and must be determined proportionally for each insurer in accordance with the number of SEUs of that insurer in the quarter immediately before the payment is made.

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Subrule 19 (5) states that non-levy in subrule 19 (4) means an amount referred to in subsection 318-5 of the *Private Health Insurance Act 2007*, other than the levy.

PART 4 – Calculating adjustment amounts

20. References to 'the Special Account'

Rule 20 provides that in Part 4, references to 'the Special Account' mean the Risk Equalisation Special Account or the Risk Equalisation Trust Fund established by section 318-1 of the *Private Health Insurance Act 2007* as in force immediately before the commencement of Schedule 1, Part 1, Division 1 of the *Private Health Insurance (Prudential Supervision) (Consequential Amendments and Transitional Provisions) Act 2015*, as the case requires.

21. Calculation where error in amount paid as levy or amount debited from the Special Account

Subrule 21 (1) provides that if APRA receives new information concerning a matter mentioned in subrule 9 (2) of the Rules, subrule 7 (2) of the old rules, as the case may be, that, if received earlier, would have affected the primary calculation under the relevant provision, APRA must make a new calculation of the amount that would have been the levy or would have been debited from the Special Account in respect of that quarter, taking into account the new information.

A primary calculation is defined in subrule 21 (1) to mean a calculation was made of the amount to be paid by an insurer as levy for a quarter, for crediting to the Special Account, or an amount to be debited from the Special Account for payment to the insurer for the quarter under Rule 13 or 18, or under rule 11 or 16 of the old rules.

Subrule 21 (2) provides that, unless subrule 21 (3) applies, a new calculation may only be made if the new information is received by APRA during or by the end of the first quarter following the financial year in which the particular quarter concerned occurs, or, within the period for submitting the reporting document to APRA (under the *Financial Sector (Collection of Data) Act 2001)* which relates to the whole of the financial year in which the particular quarter occurs, where the reporting document is used by APRA for the purposes of preparing APRA's report under section 167 of the *Private Health Insurance (Prudential Supervision) Act 2015* for that financial year.

Subrule 21 (3) provides that a new calculation may be made as a result of new information received by APRA later than is allowed under subrule 21 (2) if APRA is satisfied that the new information demonstrates that in preparing the reporting documents referred to in paragraph 21 (2) (b), the insurer made a significant error, and, it is in the best interest of insurers generally and the good administration of the Special Account that a further calculation be made.

22. Application of new calculation to determine adjustment amount

Subrule 22 (1) provides that if APRA makes a new calculation under Rule 21 APRA must determine the adjustment amount in respect of the insurer for the quarter immediately following the calculation unless subrule 22 (3) applies.

Subrule 22 (2) provides that APRA must determine the adjustment amount by having regard to:

- the difference between the amount paid as levy by the insurer or the amount debited from the Special Account and paid to the insurer; and
- the amount that the new calculation demonstrates should have been paid as levy, or paid to that insurer.

Subrule 22 (3) provides that if APRA is satisfied that the financial stability of a particular insurer would be unreasonably affected if the whole of the adjustment amount for that insurer were taken into account in one quarter, or, the Special Account would be unreasonably affected if the total of adjustment amounts for all insurers to be debited from the Special Account in one quarter were to be taken into account in that quarter, APRA may determine that an adjustment amount in respect of an insurer or insurers is to be applied over such number of quarters as APRA determines to be reasonable.

Subrule 22 (4) (a) provides that unreasonably affected in rule 22 means, in the case of an insurer, in the APRA's opinion the insurer's financial stability would be at risk if a new calculation is made under Part 4 and the adjustment amount was to be taken into account under Part 3 in one quarter.

Subrule 22 (4) (b) provides that unreasonably affected under this Part means, in the case of the Special Account, if the total of the adjustment amounts to be taken into account in determining the amounts to be paid to insurers in a quarter under Part 3 would be greater than 1% of the amount, at the time the determination is made, of the State pool of the Special Account from which the payment is to be made.

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Private Health Insurance (Risk Equalisation Policy) Rules 2025

This Legislative Instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Legislative Instrument

The *Private Health Insurance (Risk Equalisation Policy) Rules 2025* (the Rules) revoke and replace the *Private Health Insurance (Risk Equalisation Policy) Rules 2015* (the Previous Rules).

The Rules differ from the Previous Rules by updating definitions for 'age based pool or ABP', 'Business Rules', 'designated threshold', 'eligible benefit', 'gross benefit', 'hospital policy', 'quarter', 'Risk Equalisation Administration Rules', 'single equivalent unit' and 'state'. The Rules also include minor updates that do not alter the intent of the Rules.

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As part of the consultation, it was proposed that the Previous Rules remained fit for purpose and should be replaced substantially in the same form. In the consultation paper the department provided details of proposed minor amendments to the Previous Rules, sought to understand whether the Previous Rules are considered fit for purpose by those who rely on them, and sought feedback on the proposed amendments.

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Additional consultation occurred directly with the financial regulator (APRA), the Office of Impact Assessment and the Private Health Insurance Ombudsman. All agencies consulted supported the remaking of the Rules with the proposed minor amendments.

Human rights implications

This legislative instrument engages Articles 2 and 12 of the International Covenant on Economic, Social and Cultural Rights by assisting with the progressive realisation by all appropriate means of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Private health insurance regulation assists with the advancement of these human rights by improving the governing framework for private health insurance in the interests of consumers. Private health insurance regulation aims to encourage insurers and providers of private health goods and services to provide better value for money to consumers, to improve information provided to consumers of private health services to allow consumers to make more informed choices when purchasing services and requires insurers not to differentiate the premiums they charge according to individual health characteristics such as poor health.

Conclusion

This legislative instrument is compatible with human rights because it advances the protection of human rights.

Paul McBride

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