



Private Health Insurance (Risk Equalisation Policy) Rules 2025

I, Paul McBride, delegate of the Minister for Health and Ageing, make the following rules.

Dated, 30 July 2025

Paul McBride
Assistant Secretary
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Part 1 Preliminary

1 Name

This instrument is the *Private Health Insurance (Risk Equalisation Policy) Rules 2025*.

2 Commencement

- (1) Each provision of this instrument specified in column 1 of the table commences, or is taken to have commenced, in accordance with column 2 of the table. Any other statement in column 2 has effect according to its terms.

Commencement information		
Column 1	Column 2	Column 3
Provisions	Commencement	Date/Details
1. The whole of this instrument	30 September 2025	

Note: This table relates only to the provisions of this instrument as originally made. It will not be amended to deal with any later amendments of this instrument.

- (2) Any information in column 3 of the table is not part of this instrument. Information may be inserted in this column, or information in it may be edited, in any published version of this instrument.

3 Authority

This instrument is made under the *Private Health insurance Act 2007*.

4 Definitions

Note 1: A number of expressions used in this instrument are defined in the Act, including the following:

- (a) adult;
- (b) complying health insurance policy;
- (c) general treatment;
- (d) health benefits fund;
- (e) hospital-substitute treatment;
- (f) hospital treatment;
- (g) medicare benefit;
- (h) policy holder;
- (i) private health insurer;
- (j) risk equalisation jurisdiction;
- (k) risk equalisation levy;
- (l) Risk Equalisation Special Account.

In this instrument:

Act means the *Private Health Insurance Act 2007*.

adjustment amount means an amount calculated under Part 4.

age based pool or **ABP** means the pool referred to in paragraph 9 (3) (a).

APRA means the Australian Prudential Regulation Authority.

benefit paid means a benefit paid by an insurer, in accordance with a policy, to or on behalf of an insured person covered by that policy.

Business Rules means *Private Health Insurance (Health Insurance Business) Rules 2018*.

designated threshold, for an insured person, means the threshold specified in subrule 9 (10).

eligible benefit has the meaning given by subrule 7 (1).

gross benefit means the total eligible benefits paid by an insurer in respect of an insured person, in respect of treatment provided to the insured person while they fall within a particular age cohort set out in the table in subrule 9 (5).

hospital policy means a policy which covers hospital treatment.

insured person means a person who receives the treatment to which the eligible benefit paid by the insurer to a policy holder relates.

insurer means a private health insurer.

levy means risk equalisation levy.

Levy Act means the *Private Health Insurance (Risk Equalisation Levy) Act 2003*.

old rules means the *Private Health Insurance (Risk Equalisation Policy) Rules 2015*, as in force immediately before the commencement of this instrument.

policy means a complying health insurance policy.

quarter means a period of 3 months ending on 31 March, 30 June, 30 September or 31 December in a year and, in respect of calculation of amounts under this instrument, means the quarter to which the calculation relates.

quarterly return has the same meaning as in the Risk Equalisation Administration Rules.

Risk Equalisation Administration Rules means the *Private Health Insurance (Risk Equalisation Administration) Rules 2025*.

risk equalisation levy day has the same meaning as in the *Private Health Insurance (Risk Equalisation Levy) Act 2003*.

single equivalent unit, for a policy, means the number that applies under rule 6 to the category of policy that the policy falls into.

Special Account means the Risk Equalisation Special Account.

State means an area specified as a risk equalisation jurisdiction in Private Health Insurance (Health Benefits Fund Policy) Rules made under the Act, as made and in force from time to time.

Note 2: The risk equalisation jurisdictions are:

- the Northern Territory;
- New South Wales, Norfolk Island and the Australian Capital Territory;

- Western Australia including the Territory of Christmas Island and the Territory of Cocos (Keeling) Islands; and
- each of the other States.

5 Schedules

Each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

6 Single equivalent unit

- (1) The single equivalent unit for a policy is the number in column 2 of the table for the category of policy described in column 1 that applies to the policy.

Item	Column 1 Category of policy	Column 2 Single equivalent unit
1	A hospital policy under which only one person is insured	1
2	A hospital policy under which 2 adults are insured (and no-one else)	2
3	A hospital policy under which 2 or more people are insured, none of whom is an adult	1
4	A hospital policy under which 2 or more people are insured, only one of whom is an adult	1
5	A hospital policy under which 3 or more people are insured, only 2 of whom are adults	2

Note: Hospital policy means a policy which covers any hospital treatment—see rule 4.

7 Eligible benefits

- (1) **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.

Note: Policy means a complying health insurance policy—see rule 4.

(2) In this rule, the following terms have the same meaning as in the Business Rules:

- (a) ***allied health service***;
- (b) ***chronic disease***;
- (c) ***chronic disease management program***;
- (d) ***risk factors for chronic disease***.

Note 1 : The Business Rules exclude some classes of treatment from the definition of hospital treatment.

Note 2: Benefits are not payable for any treatment for chronic disease management for which a medicare benefit is payable—see section 121-10 of the Act.

(3) For the avoidance of doubt, benefits not covered by paragraphs (1) (a) and (1) (d) include benefits paid for any other treatment as part of a chronic disease management program including, but not limited, to:

- (a) diagnosis of chronic disease;
- (b) the identification of risk factors.

Part 2 Calculation of levy

8 Purpose of this part

For paragraph 318-10 (2) (c) of the Act, this Part specifies 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

- (1) The matters mentioned in this rule are to be taken into account on a State-by-State basis consistently with the information provided by the insurer in its quarterly return for a health benefits fund for a State.
- (2) The amount of levy for a quarter for an insurer, for each health benefits fund of that insurer, is to be worked out having regard to:
 - (a) the age of each insured person in respect of whom an eligible benefit is paid in that quarter; and
 - (b) the mean number for that quarter of single equivalent units for that fund, being the number determined by adding the number of such units on the last day of the previous quarter and the number of such units on the last day of the quarter for which the levy is being calculated, and halving the result; and
 - (c) the amount of eligible benefit paid in that quarter and in the preceding 3 quarters; and
 - (d) any adjustment amount.
- (3) To work out the amount of levy in respect of a current quarter:
 - (a) an amount calculated in accordance with subrule (4) is first to be notionally allocated to a pool called the age based pool (**ABP**); and
 - (b) 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, in the current and preceding 3 quarters is greater than the **designated threshold**, a second amount is to be notionally allocated to a pool called the high cost claimants pool (**HCCP**).
- (4) The amount to be notionally allocated to the ABP in a quarter is to be calculated in accordance with the formula pC , where:
 - (a) **p** is the percentage of the eligible benefit paid having regard to the age cohort, as specified in the table in subrule (5), into which the insured person falls on the day or days on which the insured person receives the treatment to which the eligible benefit relates; and
 - (b) **C** is the gross benefit in the current quarter.

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- (5) The age cohorts are as specified in the following table:

Age cohorts	
Age	% of eligible benefits included in pool
0-54	0.0%
55-59	15%
60-64	42.5%
65-69	60%
70-74	70%
75-79	76%
80-84	78%
85+	82%

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

Example: Mr X, a 59-year-old insured person whose birthday is on 24 January is admitted to hospital on January 19. Mr X is discharged from the hospital on 29 January. Mr X's gross benefit is \$10,000. In this case, as half the time in which Mr X was receiving treatment was spent while he was 59 years old and the other half while he was 60 years old, the amount to be notionally allocated to the ABP will use the rates in both the 55-59 and the 60-64 age cohorts. Therefore, the amount notionally allocated to the ABP will be: $0.5 * \$10,000 * 15\% + 0.5 * \$10,000 * 42.5\%$ which equals \$2,875.

- (7) 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.
- (8) The amount to be notionally allocated to the HCCP is to be calculated in accordance with the formula $m(R-T) - H$, where:
- (a) **m** is 82%;
 - (b) **R** is the total gross benefit for the current and the preceding 3 quarters less the amount notionally allocated to the ABP under subrule (4), or subrule 7(4) of the old rules, as appropriate, in the current and preceding 3 quarters;
 - (c) **T** is the designated threshold;
 - (d) **H** is the sum of the amounts notionally allocated to the HCCP under this rule, or rule 7 of the old rules, as appropriate, in the preceding 3 quarters.

Example 1: Mr X is 63 and has a gross benefit of \$100,000. In this case, the amount that will be notionally allocated to the ABP is \$42,500 (42.5% * \$100,000). Assuming that Mr X has not made a previous claim in the preceding 3 quarters, Mr X will be above the

\$50,000 threshold. That is, \$57,500 (the amount not notionally allocated to ABP in the current quarter with no other claims in the preceding 3 quarters) exceeds the designated threshold of \$50,000. Here, the amount that will be notionally allocated to the HCCP is \$6,150 ($82\% * (\$57,500 - \$50,000) - 0$). As there are no gross benefits in the preceding 3 quarters, the only amount that was not allocated to the ABP is the amount in the current quarter (ie, $\$100,000 - 42,500 = \$57,500$) and the amount notionally allocated to the HCCP in the preceding 3 quarters is zero.

Example 2: Assuming that, in the next quarter, Mr X has another gross benefit of \$100,000 and is still 63, the amount to be notionally allocated to the ABP will be the same as in the previous example. That is, the amount allocated to the ABP will be \$42,500. The calculation of the total amount not notionally allocated to the ABP will need to account for the previous claim amount in Example 1 for the purposes of calculating whether the total amount not allocated to the ABP exceeds the designated threshold. In this case, the total residual amount will be \$115,000 (\$57,500 (amount not allocated in the ABP in the previous quarter) + \$57,500 (amount not allocated in the ABP in the current quarter)). The result is that the total amount not allocated to the ABP in the current quarter and in the preceding 3 quarters of \$115,000 exceeds the designated threshold of \$50,000. Subject to the limit in subrule 0, the amount to be notionally allocated to the HCCP in this case will be \$47,150, which represents 82% of the difference between the sum of the total amount not allocated to the ABP in the current and in the preceding 3 quarters (\$57,500 + \$57,500) and the threshold (\$50,000), minus the sum of the amount notionally allocated to the HCCP in the preceding 3 quarters (in this case, as there was only one amount in the previous quarter, the sum is \$6,150).

- (9) Where the amount notionally allocated to the HCCP under subrule (7) exceeds (m-p)C where:
- (a) **m** is 82%;
 - (b) **p** is the percentage of the eligible benefit paid having regard to the age cohort set out in the table in subrule (5) into which the insured person falls on the day or days on which the insured person receives the treatment to which the eligible benefit relates;
 - (c) **C** is the gross benefit in the current quarter,

then the amount notionally allocated to the HCCP will be the amount calculated using the formula (m-p)C.

Example: In the case of Example 2 under subrule (7) above, the amount allocated to the HCCP is \$47,150. The maximum under subrule 0 that can be notionally allocated is \$39,500 (\$100,000 (the gross benefit) multiplied by 0.82 (the HCCP percentage) minus 0.425 (the ABP cohort percentage)). As the maximum calculated using (m-p)C of \$39,500 is less than \$47,150, the amount to be notionally allocated to the HCCP will be \$39,500.

- (10) The designated threshold for an insured person is \$50,000.

10 Payments by former insurer

- (1) Where:
- (a) an insurer (**former insurer**) has paid an amount of eligible benefit in respect of an insured person; and
 - (b) the insured person ceases to be covered by a policy of the former insurer and becomes covered by another insurer,

the amount of eligible benefit paid is to continue to be treated as a payment by the former insurer.

11 Payments where a health benefits fund is transferred

(1) Where:

- (a) an insurer has paid an eligible benefit; and
- (b) the health benefits fund of that insurer is transferred to another fund, whether of that insurer or another insurer (*receiving fund*), resulting in the policy under which the benefit was paid becoming referable to another fund,

the eligible benefit paid is to be treated as a benefit paid in respect of the receiving fund.

(2) Where:

- (a) an insurer has paid an amount of levy on the basis of the eligible benefit paid by a health benefits fund of that insurer; and
- (b) that health benefits fund is transferred to another fund, whether of that insurer or another insurer (*receiving fund*), resulting in the policy under which the benefit was paid becoming referable to another fund,

the levy paid is to be treated as a levy in respect of the receiving fund.

12 Effect of unpaid premiums

(1) If the premiums for a policy have not been paid for a period longer than:

- (a) 2 months after the end of the period for which premiums were last paid or, if the rules of the insurer allow a longer period—that longer period; and
- (b) the insurer has given written notice to the person in whose name the policy is held that the policy is no longer in operation (*terminated policy*),

a single equivalent unit is not to be taken into account for that terminated policy in determining the mean number referred to in paragraph 9 (2) (b) for the insurer's health benefits fund.

13 Method of working out

(1) The following method is to be applied in working out the amount (if any) of levy for each health benefits fund of an insurer (*Insurer Z*) for a particular quarter in respect of a State:

- (a) calculate, for each fund, the amount that is the sum of:
 - (i) the total amount of the eligible benefits notionally allocated for the quarter in that State to the ABP, as mentioned in subrule 9 (4); and
 - (ii) the total amount of the eligible benefits notionally allocated for the quarter in that State to the HCCP, in accordance with subrule 9 (7) or, if applicable, subrule 9 (9);
- (b) add the amounts calculated under paragraph (a) for each fund to obtain a total for the State;
- (c) ascertain the number that is the total of the average number of single equivalent units in that State for the quarter for all funds by:
 - (i) determining, under paragraph 9 (2) (b), the mean number of single equivalent units for each fund in the State; and
 - (ii) adding the number determined under subparagraph (i);

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- (d) calculate the average amount payable for each single equivalent unit by dividing the total amount determined under paragraph (b) by the total number ascertained under paragraph (c);
 - (e) calculate the total amount that would have been payable by Insurer Z in respect of the fund if the single equivalent units determined under paragraph 9 (2) (b) to be the mean number of single equivalent units in that State for the fund had each been entitled to the amount calculated under paragraph (d) by multiplying the amount calculated in paragraph (d) by the mean number of single equivalent units for Insurer Z as calculated in subparagraph (c) (i);
 - (f) calculate the difference between the amount calculated under paragraph (e) and the amount calculated under paragraph (a) for Insurer Z.
- (2) 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.
 - (3) Where an insurer fails to provide a quarterly return to APRA that is necessary to enable APRA to carry out the calculation referred to in this rule, APRA must carry out the calculation using the quarterly return 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 out rate of levy

- (1) Subject to subrule (2), if the amount calculated under paragraph 13 (1) (a) for an insurer is less than the amount calculated under paragraph 13 (1) (e), having taken into account any adjustment amount, the rate of risk equalisation 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.
- (2) If an insurer conducts more than one health benefits fund in one or more States, the rate of levy for that insurer is to be 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

- (1) For subsection 318-10 (2) of the Act, this Part 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

- (1) 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.
- (2) Rule 12 has the same application to this rule as it has to rule 9.

17 Method for working out amounts to be paid to insurers

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 health benefits fund and 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 to be paid an amount and amount of payment

- (1) 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), having taken account of 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.
- (2) If an insurer conducts more than one health benefits fund in one or more State, 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

- (1) Subject to subrule (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.
- (2) 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.

- (3) 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.
- (4) Where non-levy is credited to the Special Account APRA may debit from the Account amounts up to that amount of non-levy for payment 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 single equivalent units of that insurer in the quarter immediately before the payment is made.
- (5) In subrule (4), *non-levy* means an amount referred to in section 318-5 of the Act, other than the levy.

Part 4 Calculating adjustment amounts

20 References to 'the Special Account'

In this Part, references to 'the Special Account' mean the Risk Equalisation Special Account or the Risk Equalisation Trust Fund established by section 318-1 of the Act 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

- (1) If a calculation (the **primary 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 rule 11 or 16 of the old rules, as appropriate, and APRA receives information (**new information**) on a matter mentioned in subrule 9 (2), or 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 account of the new information.
- (2) Unless subrule (3) applies, a new calculation may only be made if the new information is received by APRA:
 - (a) during or by the end of the first quarter following the financial year in which the particular quarter concerned occurs; or
 - (b) 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.
- (3) A new calculation may be made as a result of new information received later than is allowed under subrule (2) if APRA is satisfied that:
 - (a) the new information demonstrates that, in preparing the reporting document referred to in paragraph 21(2)(b), the insurer made a significant error; and
 - (b) it is in the best interests of insurers generally, and good administration of the Special Account, that a further calculation be made.

22 Application of new calculation to determine adjustment amount

- (1) 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 (3) applies.

(2) 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.

(3) If APRA is satisfied that:

- (a) 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
- (b) 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 taken into account in that quarter,

APRA may determine that an adjustment amount in respect of a particular insurer or particular insurers is to be applied over such number of quarters (proportional, or as otherwise decided by APRA) as APRA determines to be reasonable.

(4) In this rule, ***unreasonably affected*** means:

- (a) in the case of an insurer, if a new calculation is made under this Part and the adjustment amount was to be taken into account under Part 3 in one quarter, the financial stability of the insurer would, in the opinion of APRA, be at risk; or
- (b) 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.

Schedule 1—Repeals

Private Health Insurance (Risk Equalisation Policy) Rules 2015

1 The whole of the instrument

Repeal the instrument.