Australian
Private Hospitals
Association

Private Health Insurance Sunsetting Rules

SUBMISSION ON THE REMAKING OF PHI INSTRUMENTS

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Contents

Executive Summary

The Australian Private Hospitals Association (APHA) welcomes the opportunity to provide a submission in response to the Department of Health, Disability and Ageing's consultation on the remaking of private health insurance (PHI) legislative instruments due to sunset in April and October 2027.

APHA's position is that the current instruments, while broadly appropriate in structure, contain a number of provisions that are materially deficient from the perspective of private hospitals. The sunsetting process provides a necessary and time-limited opportunity to correct these deficiencies. The Department's proposal to retain the instruments with minor administrative updates alone is insufficient. A simple remake without substantive reform in several key areas will entrench provisions that undermine hospital viability, clinical autonomy, and fair contracting.

APHA's key concerns are as follows:

- The minimum benefit rates set out in Schedule 1, Part 1, rule 2 of the Benefit Requirements Rules have not kept pace with the real cost of delivering hospital services and require an evidence-based review and increase.
- The definition of 'obstetric patient' in Schedule 1, rule 5 of the Benefit Requirements Rules is triggered by reference to specific MBS items or the commencement of labour. This leaves a gap for patients admitted for obstetric-related clinical management prior to those trigger events, with the hospital bearing uncompensated costs.
- The definitions of 'psychiatric patient' and 'rehabilitation patient' in Schedule 1, rules 7 and 8 of the Benefit Requirements Rules, tie higher minimum benefit rates to the existence of a 'specific treatment program'. The absence of any objective or clinical standard for what constitutes such a program, and the discretion this creates in the contracting environment, is of significant concern to private hospitals.
- The certification requirements for Type B procedures (Schedule 1, rule 10) and overnight Type C procedures (Schedule 1, rule 11) impose administrative burden on private hospitals and clinicians without adequate safeguards against insurer misuse.
- Schedule 3, rule 7's definition of a 'certified Type C procedure' creates ambiguity for situations where a Type C procedure, one that 'does not normally require hospital treatment', in fact requires hospital treatment in a particular clinical case.
- The second-tier default benefit framework in Schedule 5 requires strengthening in several respects: the minimum benefit floor under rule 3(4) should be lifted from 85% to 90%; the absence of a formal grievance mechanism for hospitals is a material gap; the prohibition on charging out-of-pocket costs imposed by some insurers under gap schemes has no legislative basis and should be addressed expressly.
- Rule 5A of the Complying Product Rules prohibits benefit reductions based on the number of psychiatric treatments, a protection APHA strongly supports, but the interaction with restricted cover provisions in Schedule 4 and rule 11G means psychiatric services at private hospitals can still be effectively limited to minimum benefits. This warrants reform.

Part 1: Private Health Insurance (Benefit Requirements) Rules 2011

1.1 SCHEDULE 1, PART 1, RULE 2 — MINIMUM BENEFIT RATES

The minimum benefit rates prescribed under Schedule 1, Part 1, rule 2 have not been adequately indexed to the real and growing cost of delivering private hospital services. The current rates bear no relationship to actual hospital accommodation costs in any jurisdiction. These rates represent the statutory floor, and while negotiated agreements can sometimes produce higher payments, the floor rates directly affect the quantum of second-tier default benefits and govern the position of patients at hospitals without negotiated agreements.

Over the past decade, private hospitals have faced sustained cost pressures: enterprise bargaining outcomes well above CPI, escalating costs of medical consumables, energy, and compliance, and a materially more complex patient cohort than the rates were designed to accommodate. The failure to maintain minimum rates at an adequate level has a compounding effect, depressing second-tier benefit calculations under Schedule 5, eroding negotiating benchmarks, and contributing directly to financial pressure on private hospitals. APHA recommends:

- A comprehensive, evidence-based review of all minimum benefit rates in Schedules 1, 2, 3 and 4, informed by current cost benchmarks across hospital types, patient cohorts and jurisdictions.
- That the remade instrument incorporate an automatic indexation mechanism, by reference to the Wage Price Index or health-specific cost indices, to ensure minimum rates do not become structurally inadequate over the life of the instrument.
- That the Department publish data comparing current minimum rates against actual average accommodation charges to inform transparent public debate on the adequacy of the current floors.

1.2 SCHEDULE 1, PART 2, RULE 5 — DEFINITION OF OBSTETRIC PATIENT

Rule 5(2) provides that a patient is taken to be an obstetric patient from the earlier of: the day on which the patient commences labour leading to delivery (cl 5(2)(a)(i)); the day on which a professional service with a specified MBS item number is rendered (cl 5(2)(a)(ii)); the day before a professional service with item 16520 or 16522 (including caesarean) is rendered, unless a longer pre-operative period is recognised (cl 5(2)(b)); or the day on which a service with a participating midwife item number is rendered (cl 5(2)(c)).

The practical consequence of this structure is that a patient admitted for monitoring, management of pre-term complications, or preparatory clinical assessment, prior to any of the rule 5(2) trigger events occurring, is classified as an 'other patient' under rule 9, attracting a lower rate per night rather than the obstetric rate. Hospitals bear the cost differential without any mechanism for recovery. The longer and more clinically complex the pre-trigger admission, the greater the uncompensated cost.

APHA recommends:

- That rule 5(2) be amended to include an additional paragraph providing that a patient admitted to hospital for the primary purpose of obstetric-related clinical management, as certified by the treating obstetrician or midwife at the time of admission, is taken to be an obstetric patient from the date of that admission, regardless of whether a rule 5(2)(a) or (b) trigger event has yet occurred.

- That the reference to 'unless the particular obstetric procedure to be rendered is recognised as requiring a longer pre-operative period' in rule 5(2)(b) be given a defined operational mechanism, including what evidence of recognition is required and by whom.

- That the Department consult with APHA, obstetric clinicians, and midwifery bodies on appropriate MBS item triggers and pre-admission admission categories to address the current gap.

1.3 SCHEDULE 1, PART 2, RULES 7 AND 8 — DEFINITIONS OF PSYCHIATRIC PATIENT AND REHABILITATION PATIENT

Rule 7 defines a psychiatric patient as a patient admitted for the purposes of undertaking a specific psychiatric treatment program that is deemed by the insurer to be relevant and appropriate for the treatment of the patient's disease, injury or condition. Rule 8 contains an identical structure for rehabilitation patients.

The insertion of insurer determinative power into both definitions is deeply problematic. The determination of whether a treatment program is 'relevant and appropriate' for a patient's condition is a clinical judgment that belongs to the treating clinician, not a commercial determination to be made by a health insurer. The effect of the current drafting is to give insurers a unilateral and legally operative power to reclassify a patient, deny the higher psychiatric or rehabilitation minimum benefit rate, and expose the hospital to an uncompensated gap.

In practice, the deeming power has consequences beyond individual benefit disputes. It can be used by insurers as leverage in the negotiation of hospital contracts. Hospitals that do not agree to insurer-preferred terms risk having their treatment programs deemed inappropriate on a systematic basis. This is an asymmetric commercial dynamic that the legislation ostensibly enables. APHA recommends:

- That rules 7 and 8 be amended to remove the insurer deeming power and replace it with an objective clinical standard: a patient is a psychiatric patient or rehabilitation patient where a treating clinician with relevant specialist qualifications certifies that the patient is admitted for the purpose of undertaking a specific psychiatric or rehabilitation program that is clinically appropriate for the patient's condition.

- That where an insurer disputes a clinical categorisation, the instrument provide a defined independent dispute resolution mechanism with a clinically qualified arbiter, rather than allowing the insurer to unilaterally reclassify a patient and reduce the applicable minimum benefit.

- That the Department review whether the insurer deeming powers in rules 7 and 8 are consistent with the principle of clinical autonomy and with the professional responsibilities of treating specialists.

1.4 SCHEDULE 1, PART 3, RULES 10 AND 11 — CERTIFICATION OF TYPE B AND OVERNIGHT TYPE C PROCEDURES

Rule 10 provides that a Type B procedure may be certified where it would be contrary to accepted medical practice to provide the procedure other than as overnight hospital treatment. Rule 11 provides an analogous pathway for overnight Type C procedures.

In principle this certification framework serves a legitimate purpose. In practice, however, the absence of defined timeframes for insurer review, and clear consequences for unjustified rejection, means the process is routinely weaponised against hospitals. Insurers interrogate certifications retrospectively, demand further clinical justification, and in some cases treat the certification process as a basis for delaying or reducing benefit payment. The administrative burden falls entirely on the certifying clinician and the hospital; the benefit of disputing a certification falls entirely to the insurer. APHA recommends:

- That the instrument specify a defined period within which an insurer must accept or formally dispute a certification, with a 'deemed accepted' outcome if no dispute is lodged within that period.
- That retrospective reclassification of a certified procedure, after benefits have been paid on the basis of the certification, be prohibited except where the insurer can demonstrate fraud or material misrepresentation.
- That consideration be given to a 'deemed certified' mechanism where the treating clinician documents the clinical basis for overnight admission in the medical record at the time of admission, without a separate written certification being required.

1.5 SCHEDULE 2 — OVERNIGHT SHARED WARD ACCOMMODATION AT PUBLIC HOSPITALS

Schedule 2 applies to overnight shared ward accommodation for private patients at public hospitals in ACT, NSW, Northern Territory, QLD, SA and WA (Victoria and Tasmania being covered by Schedule 1, Part 1, Tables 2 and 3). While the dollar amounts in Schedule 2 are set by reference to the relevant State rather than mirroring the Schedule 1, Part 1, Table 1 private hospital rates exactly, APHA's analysis identifies a structural concern: the existence of two parallel minimum benefit regimes, one for private hospitals and one for public hospitals treating private patients, creates the potential for perverse incentives where private patients are financially better served by treatment in a public hospital environment.

This is inconsistent with the policy objective of encouraging private health insurance uptake and relieving pressure on the public hospital system. APHA recommends:

- That the Department conduct a systematic comparison of Schedule 1 and Schedule 2 minimum benefit rates, disaggregated by patient class and jurisdiction, to identify and correct any anomaly by which private patients in public hospitals attract materially different minimum benefits to equivalent patients in private hospitals.
- That the outcome of any such review explicitly consider the impact on private hospital viability and the policy objective of encouraging private health insurance usage and private hospital treatment.

1.6 SCHEDULE 3, RULE 7 — CERTIFIED TYPE C PROCEDURES (SAME-DAY CONTEXT)

The note associated with rule 7 defines Type C procedures as those that do not normally require hospital treatment. That rule provides for certification of a Type C procedure for same-day accommodation purposes where it would be contrary to accepted medical practice to provide the procedure other than as same-day hospital treatment.

The regulatory gap is not in the same-day certification pathway but in the overnight context. A Type C procedure may, in a specific clinical case, by reason of patient comorbidities, procedural complexity, or unanticipated clinical need, require an overnight admission rather than same-day care. In that scenario, the treating clinician faces the same certification pathway under Schedule 1,

rule 11 (certified overnight Type C procedure), but the interaction between the Type C classification and the certification requirement is opaque, and insurers can use this ambiguity to dispute or reduce benefits.

APHA recommends:

- That Schedule 3, rule 7 and Schedule 1, rule 11 be revised together to include an express provision that a Type C procedure that is certified as requiring overnight hospital treatment in a particular clinical case is to attract the same minimum benefit as a Type B procedure, with clear operational guidance on the certification pathway and what evidence satisfies it.
- That the note to Schedule 3 clarifying that Type C procedures are procedures that 'do not normally require hospital treatment' be accompanied by express guidance that this is a normative categorisation and does not preclude overnight certification in individual clinical cases.

1.7 SCHEDULE 5 — SECOND-TIER DEFAULT BENEFITS

The second-tier default benefit framework is one of the most operationally significant parts of the Benefit Requirements Rules for private hospitals without direct insurer agreements. APHA has a number of substantive concerns about Schedule 5 as currently drafted.

1.7.1 Absence of a Compliance and Grievance Mechanism

Schedule 5 contains no mechanism by which a second-tier eligible hospital can seek redress against an insurer that imposes conditions on access to second-tier benefits or the extension of gap cover arrangements that are inconsistent with the legislative framework. This is a fundamental gap.

APHA is aware of conduct by insurers, including, most recently, conditions imposed by a particular insurer under its Medical Gap Scheme (MGS) requiring second-tier eligible hospitals to provide written undertakings not to charge patients out-of-pocket costs beyond the applicable excess or co-payment as a prerequisite to the extension of gap cover. This represents an attempt to impose commercial obligations that hospitals have not negotiated and are not required by law to accept. This conduct is possibly precisely because Schedule 5 contains no mechanism for hospitals to resist, report, or seek redress against it. APHA recommends:

- That Schedule 5 be amended to include an express compliance and grievance mechanism, enabling second-tier eligible hospitals to report and seek redress for insurer conduct that is inconsistent with the second-tier framework.
- That the Private Health Insurance Ombudsman (PHIO) be given explicit statutory jurisdiction over insurer conduct in the second-tier context, including the power to investigate and resolve disputes about the conditions imposed by insurers on second-tier hospitals.

1.7.2 Right to Charge Out-of-Pocket Costs

Schedule 5 does not expressly provide for a second-tier eligible hospital's right to charge out-of-pocket costs beyond the applicable excess or co-payment. The absence of an express right has been exploited by insurers to impose conditions on second-tier hospitals, particularly in the context of gap cover scheme extensions, that effectively require hospitals to absorb the difference between the gap scheme benefit and the hospital's charge.

There is no legislative basis for this practice. An insurer's choice to extend a gap cover arrangement to a second-tier hospital is a commercial decision; it does not, and should not, carry with it an obligation on the hospital to cap its charges. APHA recommends:

- That Schedule 5 be amended to expressly provide that a second-tier eligible hospital is entitled to charge patients out-of-pocket costs above the applicable second-tier benefit, and that no

condition imposed by an insurer as a prerequisite to the extension of gap cover arrangements may restrict this entitlement without the hospital's express written consent.

- That any insurer attempt to impose such conditions as a prerequisite to second-tier benefit payment be expressly characterised as inconsistent with the second-tier framework and subject to the grievance mechanism proposed above.

1.7.3 Enshrinement of the Second-Tier Default Benefits Guidelines

The 'Private Health Insurance — Second-tier default benefits guidelines' currently exist as non-legislative instruments. APHA submits that the substantive protections in the Guidelines should be incorporated into Schedule 5 itself, ensuring they are legally enforceable and cannot be circumvented by insurer conduct. APHA recommends:

- That the Department assess which provisions of the Guidelines are of sufficient importance to warrant legislative enshrinement in Schedule 5, consulting with hospital sector representatives on the appropriate scope.

- That at a minimum, the Guidelines' protections relating to insurer conduct, categorisation processes, and benefit payment obligations be given legislative effect.

1.7.4 Rule 1B — Internal Review of Categorisation Determinations

Rule 1B provides for internal review of a categorisation determination under rule 1A but does not prescribe the factors an authorised officer must consider. This produces inconsistency in review outcomes and limits a hospital's ability to meaningfully engage with or challenge the process. APHA recommends:

- That rule 1B be amended to include a non-exhaustive list of mandatory considerations for an authorised officer conducting an internal review, including: the hospital's patient mix and case complexity; its service offering and capital infrastructure; its financial position relative to comparable hospitals; and benchmark categorisations applied to similar hospitals in the same jurisdiction.

- That the review process be subject to minimum procedural fairness requirements, including an obligation on the authorised officer to provide the hospital with the information being relied upon and a reasonable opportunity to make submissions before a determination is finalised.

1.7.5 Rule 3(4) — Lifting the Minimum Benefit Floor from 85% to 90%

Rule 3(4) requires that the minimum benefit payable by an insurer for an episode at a second-tier eligible hospital be no less than 85% of the average charge for an equivalent episode under the insurer's negotiated agreements. This floor was calibrated at a time when the cost differential between second-tier and contracted hospitals was materially different from what it is today.

Private hospitals have experienced significant cost growth since the 85% floor was set. The residual 15% gap falls disproportionately on second-tier hospitals, which are frequently smaller, regional, or specialist facilities, that cannot absorb it without impact on service delivery or viability. APHA recommends:

- That the minimum benefit floor under rule 3(4) be lifted from 85% to 90% of the average charge for the equivalent episode under the insurer's negotiated agreements.

1.7.6 Rule 3(7)(a) — Calculation of Average Charges

Rule 3(7)(a) provides that for the purposes of calculating the average charge under rule 3(4), the charge includes the sum of the amount payable by the insurer under its negotiated agreements and any excess or co-payment amounts payable by members 'in accordance with the insurer's rules'. The

phrase 'in accordance with the insurer's rules' is problematic: it anchors the benchmark calculation to the insurer's own rule structure, giving insurers effective control over the denominator against which the 85% minimum is assessed.

An insurer could, through the design of its excess and co-payment structures, manipulate the calculated average charge downward and thereby reduce the minimum benefit floor applicable to second-tier hospitals. APHA recommends:

- That the Department review this rule to ensure it considers the specific financial and case-mix circumstances of private hospitals in determining the calculation of the average charge.

1.8 FURTHER CONCERNS

A further concern relates to the manner in which insurers discharge their obligation to pay the minimum benefits prescribed under the Rules. The minimum benefits set out in the Schedules are expressed as amounts payable per episode of care. They are, by definition, a floor.

In practice, insurers flagrantly abuse this obligation by treating the minimum benefit not as a per-episode floor but as an average to be achieved across multiple episodes. Insurers insist that averaging the minimum payment across a number of episodes is sufficient to satisfy their statutory obligation. The effect of this interpretation is that, by definition, they are routinely paying hospitals below the legislated minimum rate for individual episodes of care. Where the payment for one episode falls below the minimum but is offset by a payment above the minimum for another, the insurer treats the obligation as met, notwithstanding that the hospital has been paid less than the legislated floor for the first episode.

This is not a permissible construction of the Rules. The minimum benefit is prescribed as an amount payable in respect of an episode of hospital treatment. It is not framed as a portfolio average, and nothing in the Rules contemplates that an insurer may discharge its obligation in respect of one episode by reference to its payments for others. An averaging approach defeats the purpose of a statutory minimum: a floor that can be breached for individual episodes, provided the average across episodes is maintained, is not a floor at all. The consequence is that private hospitals are routinely paid below the legislated minimum for individual episodes of care, with no effective recourse.

APHA submits that the remaking of the instrument is an opportunity to put this issue beyond doubt. APHA recommends that the Rules be amended to state expressly that the minimum benefit is payable in respect of each individual episode of hospital treatment, and that an insurer does not satisfy its obligation by averaging payments across multiple episodes. The Rules should make clear that a payment below the prescribed minimum for any individual episode is a contravention of the benefit requirements, regardless of the level of payment for other episodes. APHA further recommends that the Department consider an express compliance and enforcement mechanism enabling hospitals to raise, and have remedied, instances in which an insurer has paid below the legislated minimum for an episode of care.

Part 2: Private Health Insurance (Complying Product) Rules 2015

2.1 RULE 5A — PSYCHIATRIC TREATMENT: PROHIBITION ON BENEFIT REDUCTIONS

Rule 5A provides that an insurance policy must not reduce a benefit for psychiatric treatment if the reduction is because of the number of psychiatric treatments provided to a person during a period. APHA strongly supports this protection, which prevents insurers from imposing day-based or episode-based caps on psychiatric benefit entitlements.

However, the practical effectiveness of rule 5A is undermined by the interaction between rule 5A, the tier framework in Schedule 4, and rule 11G. Under Schedule 4, 'hospital psychiatric services' is a clinical category that basic, bronze, and silver policies are only required to cover on a restricted basis. Under rule 11G(2), silver and bronze policies need only provide restricted cover for hospital psychiatric services. Restricted cover means the insurer pays only the statutory minimum benefit under the Benefit Requirements Rules. The result is that an insured person with a silver or bronze policy at a private psychiatric hospital may have access to psychiatric care but receive only minimum benefits, effectively making private psychiatric admission unaffordable or rendering the coverage illusory, without any breach of rule 5A.

Rule 5A prohibits reduction based on the number of treatments. It does not address the structural adequacy of the benefit provided for each treatment. The two operate as parallel mechanisms, and the tier structure effectively achieves what rule 5A was designed to prevent, by a different route. APHA recommends:

- That rule 5A be strengthened to provide that a policy must not reduce benefits for psychiatric treatment to the statutory minimum rate on the basis of the insured person's product tier, where the hospital providing treatment is a private hospital with which the insurer has a negotiated agreement that includes a contracted rate for psychiatric services.
- That the Department review whether 'hospital psychiatric services' should be elevated in Schedule 4 to require unrestricted cover for silver and gold policies, removing restricted cover as a permissible design feature for those tiers in the psychiatric context.
- That the remaking process specifically consider whether the current tier architecture for hospital psychiatric services is consistent with the Government's commitments under the National Mental Health and Suicide Prevention Plan and with the therapeutic expectations of treating psychiatrists.

2.2 RULE 4 DEFINITIONS AND PART 2B (RULES 11E, 11F, 11G) — PRODUCT TIER ARCHITECTURE

The definitions of basic, bronze, silver, and gold policies in rule 4, read with Schedule 4 and rules 11E, 11F, and 11G, establish the tier architecture for complying health insurance products. APHA's concerns are not with the tier framework as a concept but with specific features of its implementation as it applies to private hospitals.

Rule 11G(2) requires silver and bronze policies to provide unrestricted cover for most clinical categories but permits restricted cover for rehabilitation, hospital psychiatric services, and palliative care. For those three categories, restricted cover means only the statutory minimum benefit applies. For private hospitals delivering these services, restricted cover can mean the effective benefit payable is insufficient to fund the cost of the service, leaving the patient facing significant out-of-pocket exposure or the hospital absorbing an uncompensated gap.

APHA notes that rule 11G(1) requires gold policies to provide unrestricted cover for all clinical categories without exception, which is appropriate. The concern relates specifically to the silver and bronze tiers. APHA recommends:

- That the Department review whether the clinical categories eligible for restricted cover under rule 11G(2), rehabilitation, hospital psychiatric services, and palliative care, remain appropriate, and whether the scope of restricted cover adequately protects patients at private hospitals providing these services.
- That Schedule 4 be reviewed to consider whether any additional clinical categories should be elevated to mandatory inclusion at specific tiers, having regard to changes in clinical practice and private hospital service delivery since the tier framework was introduced.
- That APHA be expressly included in any consultation on amendments to Schedule 4 or rule 11G, given the direct impact on private hospital service delivery and viability.

2.3 RULE 9A — SPECIALIST PSYCHIATRIC TREATMENT: PORTABILITY REQUIREMENTS ON UPGRADE

Rule 9A modifies the standard portability requirements under section 78-1 of the Act in the context of a policy upgrade that increases psychiatric treatment benefits. Rule 9A(4) limits the waiting period an insurer can impose on a person who upgrades psychiatric cover, based on their period of pre-upgrade hospital cover. Rules 9A(6)-(8) provide for retrospective cover start dates where the upgrade occurs within five business days of an admission for specialist psychiatric treatment.

APHA supports the policy intent of rules 9A and 9B, to reduce barriers to access to specialist psychiatric care when patients upgrade their cover in response to a clinical need. However, APHA has identified a practical concern: rule 9A(6)(b) requires the upgrade to occur on or before 'the fifth business day to occur on or after the admission day'. In practice, the administrative steps required to effectuate a policy upgrade, obtain specialist advice, contact the insurer, and complete documentation, may not always be achievable within five business days, particularly where the patient's clinical condition reduces their capacity to manage administrative processes. APHA recommends:

- That the five business day window in rule 9A(6)(b) be extended to ten business days, providing more realistic time for clinically vulnerable patients to complete upgrade processes without forfeiting retrospective cover.
- That the Department clarify whether a family member or treating clinician can initiate the upgrade process on behalf of an admitted patient who lacks capacity to do so, and that the rules expressly accommodate this.

2.4 RULE 11 — PERFORMANCE INDICATORS

Rule 11 sets out the performance indicators for the purposes of section 188-1 of the Act. The current indicators, number and kind of complaints to the PHIO, changes in insured person numbers by age group, changes in episodes of hospital treatment and hospital-substitute treatment, changes in the nature of episodes, and changes in average benefits paid, are entirely focused on insurer-level and population-level metrics.

None of the rule 11 indicators capture the experience of private hospitals as providers of insured services: benefit payment timeliness, contract compliance rates, dispute frequency and resolution, or the proportion of premium revenue returned as hospital benefits. This is a significant omission. A performance framework that focuses exclusively on insurer financial performance and population utilisation trends provides a systematically incomplete picture of how the private health insurance system is functioning, and, in particular, whether it is delivering appropriate value to the private hospital sector that underpins it. APHA recommends:

- That rule 11 be amended to include additional performance indicators specifically measuring the relationship between insurers and hospitals, including: benefit payment timeliness; the rate and nature of benefit disputes between hospitals and insurers; contract compliance; and the proportion of total premium revenue returned to private hospitals as benefit payments.
- That the Department, in consultation with APHA, develop a methodology for collecting and reporting hospital-side performance data that can be incorporated into the remade instrument.

2.5 PART 4 (RULES 17 AND 18) — PILOT PROJECTS

Rule 17 specifies the kinds of pilot projects that may be conducted under section 55-15(2) of the Act: projects enabling insurers to trial new models of service delivery or health care with a limited group of policy holders. Rule 18 sets out the requirements: voluntary participation, no cost to participants, maximum four-year duration, geographic limitation only, written plan, and 28 days' notice to the Department.

APHA's concern is that rules 17 and 18, as currently drafted, do not expressly prevent a pilot project from altering or waiving benefit requirements that would otherwise apply under the Benefit Requirements Rules or the product tier requirements in Part 2B. A pilot project that, even on a limited, voluntary, and time-bound basis, can circumvent minimum benefit obligations, restructure psychiatric or rehabilitation cover, or alter the basis for second-tier benefit calculations and can cause real harm to hospitals and patients, that is not easily reversed after a four-year pilot concludes. APHA recommends:

- That rule 18 be amended to add an express requirement that no pilot project may authorise an insurer to provide benefits below the minimum benefit amounts required under the Benefit Requirements Rules, or to alter the clinical category coverage requirements in Schedule 4 or rule 11G in a manner that is more restrictive to those categories.
- That private hospitals and other health providers who are likely to be affected by a proposed pilot project be consulted as part of the 28-day notification process, not merely informed after the project commences.
- That pilot project evaluation reports be made publicly available and include a specific assessment of the impact of the pilot on private hospital operations and financial performance.

2.6 FURTHER CONCERNS

2.6.1 Bundling of Rehabilitation Benefits

There are ongoing concerns regarding the referral and payment arrangements being implemented between health insurers and acute hospitals in relation to rehabilitation, in particular, episodic bundled payment models such as the Episode Management Unit (EMU) model. These arrangements have significant adverse consequences for both standalone rehabilitation hospitals and the referring acute facilities, and the current Rules do not adequately address them.

The Association's understanding of the issue is as follows.

Standalone rehabilitation hospitals rely on referrals from external acute care facilities, both public and private. Under bundled payment arrangements, private referral hospitals enter agreements with health insurers to receive a single bundled payment covering all of a patient's care for an episode , including any after-care, under one payment. Many private acute facilities have entered episodic bundled payment arrangements in relation to orthopaedic procedures, whereby an agreed bundled amount is payable and the hospital performing the procedure is then made responsible for the medical requirements related to the episode of care, including the subsequent rehabilitation services.

This structure creates a disincentive for surgical hospitals to refer patients to external rehabilitation facilities. Because the referring hospital must allocate a portion of its bundled payment to the rehabilitation provider, the arrangement places an unreasonable financial burden on the referring hospital and introduces a risk of underpayment for the rehabilitation component of the care, potentially undermining the quality of patient outcomes.

The consequences for rehabilitation hospitals are twofold. They either fail to receive referrals at all, or they receive referrals for which they are paid by the referring acute hospital, rather than the insurer, at rates that may not reflect the complexity of the care required. Rehabilitation hospitals and units are effectively restricted to providing care for the length determined by the contract offered by the acute hospital, without the opportunity to undertake an independent pre-admission assessment. Where rehabilitation clinicians determine that extended rehabilitation is clinically necessary, the rehabilitation hospital must negotiate with the referring hospital for additional funding. This creates a misaligned financial burden and exposes both hospitals to significant risk, as the capped or bundled payment may not cover the actual cost of delivering appropriate care. That financial burden is particularly misplaced, given that insurers have ultimate responsibility to fund all of the clinically required treatment of the patients they have insured.

Surgical facilities, for their part, assume significant financial risk under these arrangements, as they are held accountable for all rehabilitation care, often without clear definitions or time limitations. If a patient requires rehabilitation months after surgery and is referred by any medical practitioner (not necessarily the operating surgeon), the acute facility may remain financially liable for that care, even where it is not involved in, or aware of, the rehabilitation episode. Moreover, if the health insurer has already reimbursed the rehabilitation provider, it may retain the right to reclaim those funds from the surgical facility, further compounding the financial exposure and administrative burden. While the risk to surgical facilities is highlighted here, the issue contributes to private hospital risk across the sector.

The underlying problem is that the bundling of rehabilitation into an acute episode payment transfers to acute hospitals, a funding responsibility that properly belongs to the insurer, severs the connection between payment and the clinically required intensity and duration of rehabilitation, and does so in a way that the Benefit Requirements Rules neither contemplate nor constrain. APHA recommends:

- That the Rules be amended to make clear that an insurer's obligation to fund clinically required rehabilitation treatment for an insured person cannot be discharged or displaced by a bundled episodic payment arrangement that transfers that funding responsibility to a referring acute facility.
- That the Rules require that rehabilitation care be funded at a level that reflects the clinical complexity and duration determined by an independent pre-admission assessment conducted by the treating rehabilitation clinicians, rather than being capped by the terms of a bundled payment negotiated between the insurer and the referring acute hospital.
- That the Department examine the EMU model and comparable bundled payment arrangements to ensure they are consistent with the insurer's primary responsibility to fund

the clinically required treatment of its insured members, and with the policy objective of a sustainable private rehabilitation sector.

Part 3: Overarching Concerns and Recommendations

In addition to the specific provisions addressed above, APHA draws the Department's attention to four overarching concerns that cut across the suite of instruments under review.

3.1 HOSPITAL VIABILITY AND FINANCIAL SUSTAINABILITY

Private hospital viability is a precondition for the functioning of the private health system and a critical pressure valve for the public hospital system. Multiple provisions across both instruments have the cumulative effect of transferring financial risk from insurers to hospitals, through inadequate minimum benefit floors, insurer deeming powers, certification requirements that favour dispute over payment, and second-tier benchmark structures that are subject to insurer manipulation. APHA calls on the Department to conduct a regulatory impact assessment of the cumulative financial effect of the current instruments on private hospital viability before the instruments are remade in their current form.

3.2 CLINICAL AUTONOMY

The Benefit Requirements Rules vest decision-making powers in health insurers, through the deeming provisions in rules 7 and 8, that belong properly to clinicians. The framework should not permit commercial insurers to override clinical judgment about appropriate treatment programs, patient classifications, or the necessity of hospital admission. The remaking of these instruments should not reproduce or entrench these provisions.

3.3 TIMELY AND APPROPRIATE BENEFIT PAYMENT

Across both instruments, the framework should ensure that private hospitals receive timely and appropriate payment for the services they deliver. The current framework contains gaps, in the second-tier benefit structure, the certification regime, the minimum benefit floor, and the performance indicator framework, that systematically disadvantage hospitals. The remaking of these instruments is an opportunity to address these gaps directly, and APHA calls on the Department to do so.

3.4 FAIR CONTRACTING

The regulatory framework has a direct effect on the negotiating environment between private hospitals and health insurers. Provisions that vest unilateral powers of classification, deeming, or approval in insurers, without corresponding accountability or transparency obligations, distort this environment. The instruments should be remade in a way that supports balanced, transparent, and commercially fair contractual relationships between hospitals and insurers.

Conclusion

APHA submits that the remaking of the sunsetting PHI instruments is an important opportunity to correct longstanding structural deficiencies that have disadvantaged private hospitals. A simple administrative remake without substantive reform is inadequate. The specific amendments recommended in this submission are grounded in the actual text of the instruments as currently in force, and are designed to address real operational and financial impacts on private hospitals.