31 March 2025

Via email: PHIconsultation@health.gov.au

Catholic Health Australia Submission: Consultation on PHI Rules – October 2025 Sunset

Thank you for the opportunity to provide feedback on the Department of Health and Aged Care's (DoHAC's) *Consultation on PHI Rules – October 2025 Sunset*. We acknowledge the importance of ensuring these legislative instruments remain fit-for-purpose and appreciate the Department of Health and Aged Care's commitment to maintaining the integrity and efficiency of the private health insurance framework.

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. Catholic providers have a vital interest in working with the Australian Government to ensure the sustainable provision of healthcare services.

CHA recognises the proposed amendments are largely administrative in nature and agree that they are a prudent step in ensuring the ongoing effectiveness of the regulatory framework. CHA has provided commentary on why these rules remain necessary, as well as some suggested areas for improvement.

If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

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Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Submission

Background

The Department of Health and Aged Care (DoHAC) and the Australian Prudential Regulation Authority (APRA) are undertaking a review of private health insurance legislation in accordance with the *Legislation Act 2003* to ensure it remains fit-for-purpose, is kept up to date and in force so long as it is needed.

This review applies to four Rules.

Three of these Rules are administered by DoHAC:

- Private Health Insurance (Risk Equalisation Policy) Rules 2015
- Private Health Insurance (Health Benefits Fund Policy) Rules 2015
- Private Health Insurance (Levy Administration) Rules 2015

One Rule is administered by APRA:

Private Health Insurance (Risk Equalisation Administration) Rules 2015

Each of the rules were analysed based on four key factors:

- **Market conditions:** This evaluates the current state of the private health insurance sector, including trends like insurer consolidation, changing demographics, and the evolving role of insurers in healthcare delivery.
- **Policy intent:** This assesses whether the original purpose and objectives of each rule remain relevant and effective in the current environment, ensuring the rules still align with their intended goals.
- **System efficiency:** This looks at how well the rules function in practice, including the administrative burden they place on insurers, the efficiency of processes, and whether there is room for improvement through technological advancements or streamlined procedures.
- **Impact on affordability:** This factor examines how the rules affect the cost of premiums for consumers, considering whether they help maintain affordability or inadvertently contribute to rising costs.

Response to questions

Do you agree that the *Private Health Insurance (Risk Equalisation Policy) Rules 2015* are fit for purpose that the law is still required?

The *Private Health Insurance (Risk Equalisation Policy) Rules 2015* were designed to support community rating by ensuring that insurers with a higher proportion of older, higher-risk members are not unfairly disadvantaged compared to those with younger, lower-risk populations. The policy effectively redistributes funds among insurers to balance out the costs of high-claiming members. Whether these rules remain fit for purpose depends on several factors:

Market conditions

The private health insurance market in Australia has experienced demographic shifts over the past decade. Younger and healthier individuals have increasingly opted out of private health insurance, leading to a higher concentration of older members in certain funds. Some insurers have strategically structured their products to attract younger, lower-risk members, potentially undermining the effectiveness of risk equalisation. By increasing the cost of gold-tier products — typically chosen by older members or those with greater healthcare needs — while lowering the cost of silver and bronze products, insurers make lower-tier policies more appealing to younger, healthier individuals. This pricing strategy can lead to risk segmentation, where higher-risk members are concentrated in more expensive products while lower-risk members opt for cheaper, lower-coverage options. As a result, the intended purpose of risk equalisation — to balance costs across the system and ensure fair access to care — is weakened, potentially driving up costs for those who need care the most and limiting the sustainability of the private health system. If current risk equalisation mechanisms do not sufficiently account for these shifts, there may be an uneven distribution of financial burden across insurers.

Policy intent

The fundamental objective of risk equalisation — supporting community rating — remains relevant. Without it, insurers with older and sicker members would face significant financial strain, leading to potential premium hikes or reduced coverage. The policy aligns with broader health system goals, ensuring access to private healthcare for all demographics, not just those who are younger and healthier. However, whether the current mechanism is the most effective way to achieve this intent remains an open question.

System efficiency

The existing model operates retrospectively, redistributing costs based on claims rather than proactively adjusting for risk. This structure may not provide strong enough incentives for insurers to focus on preventive care or cost-effective management of high-risk patients. Other models, such as prospective risk-adjusted payments or reinsurance schemes, could potentially improve system efficiency while maintaining fairness. Some international jurisdictions have adopted different approaches that could be explored for relevance in Australia.

Impact on affordability

There is an ongoing debate about whether the current risk equalisation model contributes to rising premiums. While it ensures a fairer distribution of risk, it does not necessarily encourage cost containment or innovation in service delivery. If insurers are able to shift high-cost patients into a shared funding pool without incentives to improve care management, overall costs may continue to rise, putting pressure on premiums. A review of whether the policy could be modified to enhance government cost control measures without compromising equity is warranted.

Do you agree with the proposed amendments to the *Private Health Insurance (Risk Equalisation Policy) Rules 2015*?

Given that the proposed amendments are administrative in nature and aim to ensure the rules remain current and effective, they appear to be a prudent step in maintaining the integrity and functionality of the private health insurance framework.

Do you agree that the *Private Health Insurance (Health Benefits Fund Policy) Rules 2015* are fit for purpose that the law is still required?

The *Private Health Insurance (Health Benefits Fund Policy) Rules 2015* establish requirements for private health insurers regarding how they manage their health benefits funds. This ensures that premiums collected from policyholders are used appropriately for health benefits, maintaining financial stability in the sector. Whether these rules remain fit for purpose depends on several factors:

Market conditions
The private health insurance market has experienced notable changes since 2015, including declining participation among younger demographics, increased consolidation among insurers, and growing concerns about affordability. The rise of vertical control — where insurers own or have financial interests in healthcare providers — raises serious concerns about how funds are managed and whether current regulations adequately protect policyholders. When insurers control both the funding and delivery of care, there is a risk that financial incentives will drive decisions, prioritising cost containment over patient outcomes. This could lead to restricted provider choice, pressure to steer patients toward insurer-owned facilities, and reduced transparency in how funds are allocated. Existing rules may not be sufficient to prevent conflicts of interest, ensure fair competition, or guarantee that policyholders receive the full benefits of their coverage. Stronger oversight is needed to ensure that vertically integrated insurers operate in a way that prioritises patient care and maintains the integrity of the private health system. If market trends continue to shift toward fewer large players with greater control over healthcare services, the rules may require refinements to ensure transparency and protect competition.

Policy intent
The rules were designed to ensure that health benefits funds operate with integrity, preventing cross-subsidisation between different insurance businesses (e.g. life insurance and health insurance) and ensuring premiums are used appropriately for health-related services. This intent remains valid, as financial mismanagement of health funds could compromise consumer protections and sector stability. However, changes in business models — such as increased investment in health service delivery and vertical control — would require adjustments to ensure insurers are held accountable for how they allocate and report health benefit expenditures.

System efficiency
While the current rules provide a framework for fund management, there is an opportunity to improve efficiency by streamlining reporting requirements and enhancing transparency. Ensuring that regulatory oversight remains effective without imposing unnecessary administrative burdens on insurers will be key to achieving this. If compliance costs associated with these rules are disproportionately high, it may be worth reviewing whether a more simplified or risk-based approach could achieve the same policy goals while reducing inefficiencies.

Impact on affordability
One of the most pressing concerns in private health insurance is the rising cost of premiums. While the *Health Benefits Fund Policy Rules* are not directly responsible for premium increases, they play a role in ensuring that funds are managed prudently. If insurers are permitted excessive flexibility in fund allocation, there is a risk that resources could be diverted away from core health benefits, indirectly impacting affordability. Strengthening reporting mechanisms to ensure transparency in how funds contribute to premium stability and benefit payouts could be beneficial in addressing affordability concerns.

Do you agree with the proposed amendments to the *Private Health Insurance (Health Benefits Fund Policy) Rules 2015*?

Given that the proposed amendments are administrative in nature and aim to ensure the rules remain current and effective, they appear to be a prudent step in maintaining the integrity and functionality of the private health insurance framework.

Do you agree that the *Private Health Insurance (Risk Equalisation Administration) Rules 2015* are fit for purpose that the law is still required?

The Private Health Insurance (Risk Equalisation Administration) Rules 2015 set out the administrative framework for the risk equalisation system in Australia's private health insurance sector. Whether these rules remain fit for purpose depends on several factors:

Market conditions
The private health insurance market has changed significantly since 2015. Australia's ageing population has increased pressure on insurers, with rising claims costs and fewer young people taking out policies. Risk equalisation remains crucial in maintaining stability in the sector, ensuring that insurers with older and sicker members can remain competitive. However, the increasing presence of vertically integrated insurers and evolving funding models (such as value-based care) may require adjustments to how risk equalisation is administered to prevent unintended market distortions.

Policy intent
The fundamental policy intent of risk equalisation is to support community rating by

ensuring that insurers are not financially penalised for covering higher-risk populations. This remains a necessary function in the private health system. The Risk Equalisation Administration Rules provide the mechanisms for reporting and distributing funds between insurers, ensuring the system operates effectively. While the core intent remains valid, there may be opportunities to refine the administrative framework to better align with contemporary market dynamics and improve fairness in fund distribution.

System efficiency
Administrative efficiency is essential in risk equalisation to ensure that the system does not impose excessive compliance costs on insurers or delay fund redistribution. Advances in data analytics and digital reporting systems could allow for more streamlined processes, reducing administrative overhead. Additionally, a review of reporting requirements could help ensure that the system remains transparent without placing unnecessary burdens on insurers. Simplifying the administrative processes while maintaining accuracy could improve overall system efficiency.

Impact on affordability
Risk equalisation is critical in preventing premium volatility and ensuring that insurers can continue to cover older Australians without disproportionately raising premiums. However, if the administration of risk equalisation is not optimised, there is a risk that inefficiencies could contribute to higher operating costs, indirectly affecting premium affordability. Regular reviews of the funding distribution model and adjustments to reflect changing risk profiles may help maintain premium stability while ensuring fair allocation of funds across insurers.

Do you agree with the proposed amendments to the *Private Health Insurance (Risk Equalisation Administration) Rules 2015*?

Given that the proposed amendments are administrative in nature and aim to ensure the rules remain current and effective, they appear to be a prudent step in maintaining the integrity and functionality of the private health insurance framework.

Do you agree that the *Private Health Insurance (Levy Administration) Rules 2015* are fit for purpose that the law is still required?

The *Private Health Insurance (Levy Administration) Rules 2015* govern the collection and administration of levies imposed on private health insurers, including those related to risk equalisation and other statutory obligations. These levies contribute to maintaining equity in the private health insurance sector and ensuring financial sustainability. Whether these rules remain fit for purpose depends on several factors:

Market conditions
Since 2015, the private health insurance landscape has evolved, with increased financial pressure on insurers due to rising healthcare costs and demographic shifts.

The number of younger Australians taking up private health insurance has declined, while claims from older policyholders continue to rise. The levy system remains a key mechanism for distributing financial responsibilities across insurers, but ongoing market consolidation and vertical integration may necessitate a review to ensure levies are structured fairly and do not disproportionately impact smaller or non-integrated insurers.

Policy intent
The policy intent of the *Levy Administration Rules* is to ensure that required levies are collected efficiently and transparently, contributing to the broader objectives of risk equalisation and regulatory oversight. The fundamental purpose remains valid, as levies support essential mechanisms that stabilise the private health system. However, any changes in the underlying funding structure, including potential reforms to risk equalisation or regulatory contributions, may require adjustments to ensure alignment with contemporary policy goals.

System efficiency
Efficient levy administration is critical to minimising the compliance burden on insurers while ensuring timely and accurate collection of funds. Advances in digital reporting and financial processing could allow for more streamlined administration, reducing unnecessary complexity. Additionally, a review of levy calculations and collection mechanisms could help determine whether refinements are needed to improve transparency and efficiency, ensuring that the system remains fit for purpose without imposing excessive costs on insurers.

Impact on affordability
Levy administration affects affordability by influencing the overall cost structure of insurers. If levies are not administered efficiently or are set at levels that place undue pressure on insurers, these costs could be passed on to consumers through higher premiums. A review of the rules should consider whether levy structures remain appropriate in the current economic climate and whether any adjustments are needed to maintain affordability while preserving financial sustainability.

Do you agree with the proposed amendments to the *Private Health Insurance (Levy Administration) Rules 2015*?

Given that the proposed amendments are administrative in nature and aim to ensure the rules remain current and effective, they appear to be a prudent step in maintaining the integrity and functionality of the private health insurance framework.

Are there any other changes you would recommend that would make these instruments administratively more efficient?

The current risk equalisation regulations do not account for the higher claim costs associated with pregnancy-related and mental health services. The recent Finity review, commissioned by the Department of Health and Aged Care, highlighted that access and affordability in these

areas could be improved through a hybrid risk equalisation system that "better matches expected differences in claim costs by age and sex." Specifically, the review found that such a system would provide greater support to insurers covering younger individuals who claim for pregnancy or mental health treatment. Despite strong sector-wide support, this recommendation has not been implemented. Adopting this reform is critical to ensuring maternity and mental health services remain accessible and affordable. Modelling suggests that including pregnancy in the risk equalisation pool could reduce premiums by 5–10%, easing financial barriers to essential care.

More broadly, any changes to risk equalisation should assess the both the quality and appropriateness of care. This includes a focus on value for patients — not just in terms of affordability but also:

- patient choice
- minimisation of complexity
- transparency
- sustainability of the private health sector (and, therefore, continued access for patients)

The next major productivity and efficiency opportunity for the private health sector lies in expanding out-of-hospital care. Achieving this at scale will require expanding default benefits to out-of-hospital settings, and risk equalisation models must reflect this shift.

In addition, the current retrospective risk equalisation model allows private health insurers (PHIs) to weight revenue rates toward procedures more commonly used by older patients (e.g. joint replacements) while reducing support for services used by younger patients (e.g. maternity care). This misalignment leads to private hospital reimbursement rates that do not reflect actual service costs. Any prospective risk equalisation system must address this imbalance.