



OUR POSITION

Redesigning private health insurance products for value and choice

BACKGROUND

Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, community, and aged care providers. Our members operate over 80 hospitals across each Australian state and in the Australian Capital Territory, providing around 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 Members also provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care services.

CHA not-for-profit health, community and aged care 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. CHA champions reforms aligned with the healing ministry of Christ and the work of Catholic congregations around the country.

The aim of our position statements is to outline CHA's policy and advocacy priorities on key issues that are essential to the mission and values of its members.

A more in-depth analysis of our policy positions is available through our [government submissions](#).

POSITION

Private health insurance plays a vital role in supporting Australia's public-private healthcare system, offering consumers an alternative pathway to care, fostering choice, and alleviating demand on the public sector. Historically, it has played a critical role in enabling timely access to elective procedures and specialised services, while also supporting the sustainability of the broader health system. However, in recent years, the private health insurance market has faced growing scrutiny due to increasing complexity, affordability challenges, and diminishing transparency. These issues risk undermining consumer confidence and threaten the long-term viability of private health insurance as a viable complement to public health services.

This paper presents a comprehensive analysis of the challenges facing Australia's private health insurance market and offers a set of targeted reforms aimed at restoring simplicity, enhancing consumer protections, and promoting equitable access to high-value care. By addressing these issues, the private health insurance sector can better fulfill its promise of supporting the health and wellbeing of Australians, while ensuring the sustainability of the nation's health system as a whole.



What reforms have been made to private health insurance products in the past?

In 2017, the Australian Government introduced a major package of private health insurance reforms aimed at simplifying products, improving transparency, and enhancing affordability. A key component of the reforms was the requirement for insurers to classify all hospital policies into four tiers — Gold, Silver, Bronze, and Basic — each with defined minimum clinical categories that policies in that tier must cover. The intent was to give consumers greater clarity about what their policies included and to make it easier to compare products across the market.¹

Why is the current design of private health insurance products no longer fit-for-purpose?

Complexity and lack of transparency

While the Gold, Silver, Bronze, Basic reforms achieved their initial objectives, the market has gradually become more complex and difficult for consumers to navigate.² Products often exclude essential services or include benefits that are rarely used, making it difficult for consumers to compare and choose a product that suits their health needs. Today, there are over 25,000 policies on the market, and the introduction of “Silver Plus” products — which allow insurers to offer Silver-tier policies with additional inclusions — has further blurred the lines between tiers. As a result, the promise of simpler and more transparent private health insurance has been undermined. In fact, recent analysis has found that 215 Silver and Silver Plus policies cost more than at least one Gold policy,³ making it increasingly difficult for consumers to identify value for money and choose a policy that meets their needs.

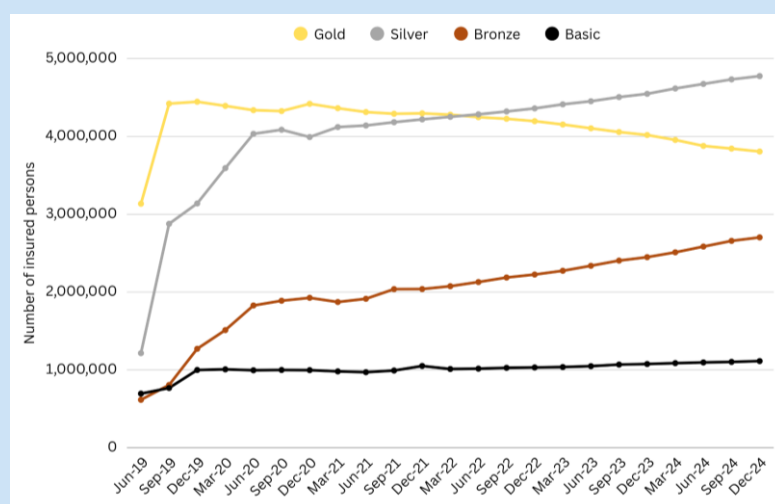
Adding to the complexity for consumers is the practice of “phoenixing,” a tactic used by many insurers. This involves closing existing products and replacing them with near-identical policies at significantly higher prices. Phoenixing undermines transparency in the private health insurance market and makes it harder for consumers to compare products or track changes over time. According to the Commonwealth Ombudsman, the practice drives up costs, limits consumer choice, and effectively bypasses the regulated annual premium increase process. For one insurer, the Ombudsman found that in 2023, the average premium of the new policy was 21 per cent higher than the closed policy it replaced. In 2024, the replacement policy remained 14 per cent more expensive than the original.⁴ This pricing tactic is making Gold-tier products increasingly unaffordable for many consumers, reducing access to the highest level of hospital cover — including essential services such as maternity care and mental health treatment.

Value erosion

Amid rising cost-of-living pressures, increasing private health insurance premiums are adding to the financial strain on Australian consumers. While the average indexation approved in the 2025 private health insurance premium round was 3.7 per cent, data analysis of the major insurers shows some Gold products increased by more than 9 per cent between 2024 and 2025.⁵ Despite these price increases, insurers are returning less to patients in terms of benefits, returning just 84.1 per cent in 2023–24 and 81.6 per cent the year before.

Due to this decline in value, Silver products have now become the dominant form of hospital cover, whereas in the past, most consumers held Gold products (Figure 1).

Figure 1: Trends in private health insurance coverage by policy tier⁶



This trend is detrimental to the sustainability of the private health system, as well as the broader health system. This shift to lower-tier policies results in reduced coverage for critical services like obstetrics, mental health, and complex surgeries, which means many patients will either pay increased out-of-pocket costs for private health services or seek care through the public health system which is already under pressure. In addition, the private health insurance system in Australia relies on a form of cross-subsidisation, where healthier individuals with Gold-tier policies who do not utilise the full extent of their coverage subsidise the costs for higher-risk patients who require more extensive medical services. This balance helps maintain the affordability and sustainability of private health insurance products. However, the recent trend of healthier individuals downgrading to Silver or Bronze products is disrupting this equilibrium. As a result, Gold products are increasingly populated by higher-acuity individuals who are more likely to claim benefits, leading to a concentration of risk and escalating costs within this tier. This places additional financial strain on insurers, prompting many to effectively price Gold products out of the market in an effort to manage risk and limit their exposure to high-cost claims.

How can private health insurance products be reformed to be more effective?

Out-of-pocket costs

In addition to rising private health insurance premium costs, private health insurance products are covering less, leaving consumers to face growing out-of-pocket expenses. While some of these costs relate to the hospital stay itself, many arise outside the hospital setting — such as fees for medical practitioners — which private health insurance typically does not cover. As a result, many insured patients are turning to the public system for care, which further strains the already overstretched public hospital system. This trend is particularly evident in private maternity care, where growing numbers of patients with Gold cover are opting for the public system due to the significant out-of-pocket costs for obstetric services — costs that private health insurance does not fully cover.

In addition to private health insurance not covering medical practitioner fees, private health insurance often falls short in funding out-of-hospital services such as hospital-in-the-home, subacute care, and digitally enabled services. Out-of-hospital services are often more efficient and effective, with lower readmission rates, shorter lengths of stay, reduced mortality, and increased patient satisfaction.⁷ In comparable countries, out-of-hospital care provides up to 20 per cent of bed capacity, while in Australia it only account for 5 per cent of private hospital care.⁸ While some insurers offer these services through separate contracts with hospitals or as part of insurer-delivered programs, their availability is inconsistent across the sector. Additionally, when insurers both fund and deliver these services, the resulting conflict of interest raises the risk of vertical control, prompting concerns that insurers may unduly influence clinical decisions and limit patient choice (see [CHA's position on insurer vertical control](#)).

Restore simplicity and transparency in private health insurance

To address the serious issues of complexity, lack of transparency, limited access, and poor value for money in private health insurance, the design of these products must be fundamentally reformed. The tiered product system introduced in 2019 was intended to simplify choices and make it easier for consumers to compare products across insurers. However, the complexity introduced since then has made it increasingly difficult for patients to navigate the system.

To restore clarity and consumer confidence, CHA recommends restandardising tiered products to ensure genuine comparability. This means tightening the rules around what services must be included in each tier and reducing the ability for insurers to market "Plus" products that blur the lines between categories. Greater transparency is also needed around the opening and closure of products to prevent practices such as "phoenixing". Restandardisation would eliminate the current grey zones that allow insurers to vary benefits significantly within a tier, which often misleads consumers into thinking they're purchasing equivalent coverage across different funds when, in fact, they are not. It would also support regulatory efforts to make like-for-like product comparisons more meaningful, curb product proliferation, and reduce reliance on complex exclusions and restrictions that currently make it difficult for consumers to assess value.

Inclusion of out-of-hospital care

Private health insurance products in Australia currently offer limited support for integrated and out-of-hospital models of care, which undermines continuity of care and restricts patient choice. CHA recommends that private health insurance products be reformed to provide broader and more consistent access to services aligned with contemporary, integrated out-of-hospital models of care. This includes community-based rehabilitation and subacute care, mental health services delivered outside of hospitals, hospital-in-the-home (HITH), and virtual or remote monitoring solutions. These models not only improve the patient experience and reduce avoidable hospital admissions, but also align with value-based care principles by promoting outcomes over volume. To achieve this, CHA recommends that out-of-hospital care be made a default benefit across all relevant insurance products. This would ensure that patients, in consultation with their treating clinicians, can make care decisions based on clinical need rather than insurer discretion.

Private health insurance products should be fundamentally redesigned to improve accessibility for population groups that have historically faced barriers to coverage. At present, the system often favours healthier, higher-income individuals, leaving behind those who are more likely to require care but less able to afford it. To create a more equitable and inclusive private health system, targeted reforms are needed to support access for Australians on lower incomes who have high healthcare needs. This could include reallocating a portion of the existing funding for the private health insurance rebate to introduce a subsidy model that reduces premiums for low-income individuals and families. It could also include looking at new ways for consumers to fund private healthcare, such as Health Savings Accounts, which are already used in several countries.

What can be changed to ensure mental health services are funded to ensure viability?

Remove anticompetitive preferred provider schemes

Competition in any market is vital to ensure lower prices, better quality products, and more choice for consumers. In addition, it stimulates innovation from businesses and increases the welfare and prosperity of all Australians.⁹ In Australia health insurers are reducing choice for consumers by creating preferred provider networks. Health insurance providers enter agreements with selected health care service providers to provide set fees for services in order to get listed as a preferred provider by the insurer.¹⁰ While the intention of these agreements are to reduce out-of-pocket costs to consumers, what they actually achieve is funnelling patients to service providers that are chosen by an insurance company rather than the clinician and patient. Patients suffer a financial penalty if they do not seek treatment with an insurance company's preferred provider, reducing choice for patients.¹¹ CHA recommends that preferred provider schemes be regulated as to not reduce choice for consumers and advantage insurers at the expense of patients. Policyholders must be able to access the provider of their choice without financial disadvantage.

Introduce value comparison scores to improve transparency and consumer choice in private health insurance

To support consumers in making more informed decisions when comparing private health insurance products, CHA recommends that the Private Health Insurance Ombudsman publish value comparison scores. These scores should enhance the existing comparison tool on the Ombudsman's website, which currently lacks the depth and transparency needed to help consumers fully assess the value of their health insurance. The proposed value scores should allow for easy comparison across key metrics, including benefits paid for common medical services, each insurer's benefit payout ratio, and benefits paid for innovative care models such as hospital in the home.

A transparent comparison tool is essential, as benefits paid by insurers for the same medical service can vary significantly, even between products in the same tier. This variation contributes to inconsistent and often unexpected out-of-pocket costs for consumers. To accurately assess value for money, consumers need a simple way to compare how much insurers pay for commonly accessed services. It is reasonable for policyholders to expect that premium increases are reflected in improved benefits and service coverage. However, in recent years, premium increases have largely contributed to rising management expenses and insurer profits rather than being directed towards higher benefit payouts for members.

To address this, value scores should prominently include each insurer's benefit payout ratio, an essential measure of how much of members' premiums are returned in the form of care. Additionally, consumers should be able to compare benefits paid for non-hospital-based models of care, such as hospital in the home. These models deliver both system-wide cost savings and better patient outcomes, yet many insurers do not consistently fund them unless they are delivered through their own facilities or contracted providers. Reporting should distinguish between benefits paid for in-house or subcontracted services and those reimbursed when accessed through independent providers. Without this nuance, insurers could appear more supportive of these care models than they are in practice, undermining the purpose of a value score.

Expand waiting period exemptions to improve access to maternity care

Private health insurers are currently required to offer a waiting period exemption for existing policyholders who upgrade their cover to access higher benefits for psychiatric care. This exemption enables patients to access timely mental health treatment without prohibitive out-of-pocket costs and reflects a commitment to responsive, needs-based care. CHA recommends that this principle be extended to other key areas of care to improve access to affordable, high-quality services for more Australians.

One such area is maternity care. While waiting periods for maternity cover are primarily intended to prevent individuals from taking out insurance solely to claim for an imminent birth, the policy can also disadvantage those who have not planned their pregnancies and were unable to anticipate the need for upgraded cover. CHA therefore recommends that policyholders who already hold hospital cover be permitted to upgrade to a policy that includes maternity benefits without serving the standard waiting period. To maintain the integrity of the insurance system, this could be conditional on the policyholder paying a lump sum to reflect the difference in premiums over the previous 12 months. Alternatively, insurers could incentivise continuity by offering comprehensive postpartum and newborn coverage, encouraging policyholders to retain the higher level of cover for a period after the birth.

Strengthen consumer protections by regulating phoenixing

To address the growing problem of phoenixing in the private health insurance market, the Australian Government should introduce regulatory reforms that ban or tightly control the practice. Legislation should prohibit insurers from closing a product and reissuing a substantially similar one at a higher price unless there is a clear and demonstrable change in the underlying benefits or costs. In addition, insurers should be required to seek prior approval from the government before launching new or replacement products, with a formal assessment of whether the changes are in the public interest and materially different from existing offerings. To improve transparency, insurers should also be required to publicly disclose when products are opened or closed, with this information published in a central, publicly accessible registry managed by the Private Health Insurance Ombudsman. This registry should include clear links between closed products and their replacements, and reasons for the changes. Penalties should apply for insurers that circumvent these rules, including financial sanctions and restrictions on future product launches. Finally, consumer protections should be strengthened by requiring that, when a product is closed, policyholders be offered a comparable alternative at no more than CPI-adjusted pricing, unless a higher price is approved through the formal regulatory process. Finally, the system for approving premium increases should be reformed, consistent with CHA's policy position on introducing a National Private Price. These measures will help prevent price manipulation disguised as product redesign, restore accountability to the system, and protect access to comprehensive health cover for all Australians.

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⁸ Private Healthcare Australia. (2023). *There’s no place like home: reforming out-of-hospital care*. Retrieved 16/07/2025 from: https://privatehealthcareaustralia.org.au/wp-content/uploads/20230523_PHA-Report_Reforming-out-of-hospital-care.pdf

⁹ Australian Competition and Consumer Commission. (2024, August 28). *Competition and why it matters*. Retrieved 16/07/2025 from: <https://www.accc.gov.au/consumers/competition-and-why-it-matters>

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¹¹ Australian Competition and Consumer Commission. (2011). *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance*. Retrieved 16/07/2025 from: <https://www.accc.gov.au/system/files/Report%20to%20Senate%20-%20Private%20Health%20Insurance%202010%20-%202011.pdf>