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Via email: [PHIconsultations@health.gov.au](mailto:PHIconsultations@health.gov.au)

**Catholic Health Australia Submission: Outlawing private health insurance product phoenixing**

Catholic Health Australia (CHA) is pleased to provide this submission in response to the Department's consultation on *Outlawing Private Health Insurance Product Phoenixing*. CHA represents Australia's largest grouping of non-government hospitals and aged care services, and our members are directly affected by the stability, transparency, and affordability of the private health insurance system.

CHA strongly supports the Government's intention to close the legislative loophole that enables insurers to reissue near-identical products at higher premiums without ministerial approval. Product phoenixing undermines consumer confidence, distorts market transparency, and creates operational uncertainty for hospitals and patients alike. However, as outlined in our submission, phoenixing is a symptom of deeper structural pressures — including rising input costs, outdated product design frameworks, and a politically constrained premium approval process — all of which must be addressed in parallel to achieve lasting reform.

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](mailto:katharineb@cha.org.au).

Yours sincerely,



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# Catholic Health Australia

## Submission: Outlawing private health insurance (PHI) product phoenixing

October 2025

Catholic Health Australia

[www.cha.org.au](http://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 issue of product “phoenixing” in private health insurance (PHI) represents a major loophole in the current regulatory framework under the *Private Health Insurance Act 2007*. While section 66-10 of the Act requires insurers to seek ministerial approval for premium increases on existing products, insurers are not required to obtain approval when introducing new products. This loophole enables insurers to close existing products — often those with lower premiums — and reissue near-identical policies under new names at substantially higher prices. The practice allows funds to circumvent the annual PHI Premium Round and avoid public interest scrutiny of price increases.

The Commonwealth Ombudsman has raised significant concerns about the practice of product phoenixing in the private health insurance market, identifying it as a key driver of rising costs and consumer confusion. In its monitoring of insurer behaviour, the Ombudsman found that some insurers have been closing existing health insurance products and reissuing near-identical ones at higher prices, effectively bypassing the regulated annual premium approval process. In one notable example, the Ombudsman reported that an insurer’s newly released product in 2023 carried an average premium 21 per cent higher than the closed policy it replaced, and that even a year later, the replacement product remained 14 per cent more expensive than the original. The Ombudsman warned that this practice undermines transparency and fairness in the PHI market by disguising price increases as product innovation. It also noted that phoenixing restricts consumer choice, since closed products are no longer available to new members, and makes it difficult for policyholders to compare options or understand why their costs are rising. These findings have reinforced the view that stronger legislative and regulatory controls are needed to prevent insurers from exploiting this loophole and to protect consumers from unregulated premium inflation.

The Department’s consultation proposes to close this loophole by amending the PHI Act so that premiums for new products must also be subject to ministerial approval against a public interest test, mirroring the existing process for premium increases on current products. Insurers would be encouraged to submit applications for new products during the annual Premium Round, and only in exceptional circumstances outside this cycle. The reform is expected to take effect within the 2026 Premium Round year. For hospitals, these changes are critical. Product phoenixing creates financial and operational instability: it alters product design unpredictably, disrupts patient coverage, and complicates hospital–insurer contracting. A stronger, more transparent premium approval process will support both system sustainability and patient access to care.

## Overarching comments

CHA acknowledges that product phoenixing is a real and urgent problem in Australia’s private health insurance market, and we fully support efforts to close the loophole that allows insurers to circumvent premium scrutiny by replacing existing policies with near-identical, more expensive ones. However, it is equally important to recognise that phoenixing is a symptom, not the root cause, of underlying cost pressures, market misalignments, and system fragility. Any regulatory fix should be complemented by reforms that address the deeper drivers of premium

inflation, inefficiencies, supply cost escalation, and misaligned incentives between insurers, providers, and patients.

One of the core underlying issues is that the costs of delivering care have risen sharply across the private hospital sector, while funding from private health insurers has failed to keep pace — evidenced by the sector recording a \$34 million loss in 2023–24. This escalation reflects a combination of factors, including increasing staff wages, higher energy and utility costs, and the growing expense of meeting regulatory and accreditation requirements as well as ongoing capital investment in infrastructure, technology, and quality and safety standards. In addition, Australia’s ageing population and the rising prevalence of chronic and complex conditions are driving greater utilisation of high-cost services and increasing the overall acuity and complexity of patient care. At the same time, risk pool dynamics have shifted: there is evidence of membership drift, adverse selection, and under-joining by younger, lower-risk cohorts, which exacerbates claims pressure per policy.

While the costs of delivering care have been steadily increasing, the political and ministerial oversight of premium approvals exerts downward pressure on premiums, making it difficult for insurers to set prices that accurately reflect underlying cost growth. While the Minister’s involvement ensures accountability to the public, it also exposes the process to short-term political pressures — particularly around election cycles and consumer sentiment about rising health costs. This approach can create uncertainty and inconsistency, as decisions may not always reflect underlying actuarial or cost-based realities. This lack of a transparent, independent framework has likely contributed to the emergence of phoenixing behaviours, as insurers seek alternative avenues to adjust prices in response to genuine cost pressures.

Moving forward, an independent approval mechanism — such as one overseen by the Independent Hospital and Aged Care Pricing Authority (IHACPA) — would help ensure that pricing decisions are grounded in evidence, not politics. Further outlined in CHA’s [position](#) on private health insurance premiums, this approach would shift the focus from short-term political considerations to transparent, data-driven oversight. CHA advocates for a system in which premium decisions are informed by objective cost data, hospital input costs, and insurer performance metrics, including the proportion of premium revenue returned to consumers as benefits and the level of management and administrative expenditure retained by funds. This process would promote accountability, reward efficiency, and align premium approvals with the actual cost of delivering hospital care. It would also create a fairer, more predictable environment for insurers, strengthen sustainability across the private health sector, and restore public confidence that premium settings are evidence-based, balanced, and in the best interests of patients. Ultimately, establishing an independent mechanism of this kind would also lay the foundation for implementing a National Private Price, as outlined in CHA’s [policy position](#) on this reform.

In addition, the current Gold, Silver, Bronze, and Basic tier system, originally introduced to simplify private health insurance and make comparison easier for consumers, has become increasingly complex and fragmented, and is likely no longer fit for purpose. When the tier framework was established in 2020, the intention was to ensure transparency by requiring all hospital products to meet clearly defined minimum clinical categories for each level of cover. However, the introduction of flexible “Plus” products (such as Silver Plus and Bronze Plus) has blurred these distinctions, allowing insurers to add or remove inclusions at will and making the differences between tiers far less meaningful. What was meant to be a clear hierarchy of coverage has evolved into a convoluted array of overlapping and often confusing products.

This complexity has made it harder for consumers, and even providers, to determine what is actually covered under each tier. Many policies include exclusions, restrictions, co-payments, and network limits that vary widely between insurers, even when products appear to sit in the same tier. As a result, there are now hundreds of Silver and Silver Plus policies that cost more than at least one Gold product, undermining the logic of the tier structure and eroding consumer confidence. From a hospital perspective, this inconsistency creates operational and financial uncertainty, as patients often discover their cover does not extend to the procedures or hospital networks they expected. For these reasons, the current product tiers require comprehensive evaluation and reform. The definition of each tier—including the clinical categories, permitted variations, and benefit inclusions—should be reviewed to ensure they reflect modern models of hospital care and are consistent across insurers. Consideration should also be given to tightening the rules around “Plus” products or replacing them with a simpler, standardised framework that leaves less room for manipulation.

Thus, while outlawing phoenixing is a necessary corrective to prevent abuses and restore transparency, it must be paired with broader structural reforms that address the underlying pressures driving these behaviours. Sustainable premium settings cannot be achieved without sustainable hospital funding, just as hospital viability depends on a functioning, affordable insurance market. Addressing the root causes of phoenixing will require collaboration between government, insurers, and providers through mechanisms such as the Private Health CEO Forum. Only by tackling these structural and behavioural drivers can the private health system be stabilised for the long term, ensuring equitable access to care, restoring consumer trust, and maintaining the viability of Australia’s mixed public–private health system.

## **Response to questions**

**Factors that the department should be aware of in relation to insurers’ business practices, including approvals and timeframes, in developing and introducing new PHI products. What impact would the proposed legislative change and additional regulatory burden have on insurers?**

From a hospital perspective, insurers’ current ability to close and reopen products without oversight creates volatility that extends beyond the insurance market. Phoenixing disrupts continuity of patient coverage, generates confusion for consumers about what is and is not covered, and results in unpredictable admission volumes for hospitals. Contract negotiations with insurers become more complex as product line-ups shift frequently, and hospital planning for service capacity and staffing becomes more difficult. Requiring ministerial approval for new product premiums will help stabilise this environment and ensure that price movements reflect genuine cost pressures rather than marketing tactics. While insurers may argue that the change increases administrative burden, the impact is modest, as insurers already engage with the Department annually during the Premium Round process. Extending the same process to new products simply ensures consistency and fairness across the market. For hospitals, predictability in product pricing and benefits is essential for maintaining sustainable service delivery and ensuring continuity of care for privately insured patients.

**What situations would insurers consider to be ‘exceptional circumstances’ under which they may seek to apply for approval of premiums outside the annual Premium Round process? How often would insurers expect to apply outside of the annual Premium Round process?**

Exceptional circumstances should be defined narrowly to prevent abuse of the out-of-cycle process. Appropriate grounds might include situations where there is a material, unforeseen external event that significantly alters claims costs, such as an unexpected change to MBS or PBS listings, new clinical mandates, or public health emergencies requiring new benefit categories. Another valid ground would be a verified prudential risk identified by APRA that necessitates urgent product modification to protect solvency. A third category could include force majeure events, such as a cyber incident or natural disaster, that make an existing product unviable. Outside these limited circumstances, all new product premium approvals should occur through the annual Premium Round. This approach balances regulatory efficiency with prudential flexibility, while upholding the core policy goal of eliminating phoenixing.

**Factors that the department should consider when designing the proposed application forms (noting these would be subject to further consultation for each Premium Round, as per the current process) and in assessing and advising the Minister on whether an application for a premium for a new product should be approved under the public interest test.**

The application form for new product approvals should be designed to mirror the existing Premium Round templates but include new transparency requirements. Each application should include a product lineage map identifying whether the new product replaces or closely resembles an existing one. A side-by-side comparison of premiums, covered services, restrictions, co-payments, and hospital network rules should be mandatory, alongside actuarial justification for any premium increase. Applications should also include a hospital impact statement, detailing potential effects on patient access and service continuity for high-need categories such as maternity, mental health, and rehabilitation. To ensure transparency, insurers should disclose how the product will be marketed, confirm that closed products remain visible to existing members, and declare any differential treatment of new versus existing customers. The Department's assessment of the "public interest" should consider: whether the product is materially different or simply a rebrand; whether the premium increase is proportionate to genuine cost drivers; whether patient access or hospital viability would be harmed; and whether the product supports transparency and consumer choice.

**Noting that the intent of this process is to outlaw product phoenixing, any context the insurer wishes to provide about the drivers of 'product phoenixing'. What would be the likely responses by insurers as a result of removing this loophole?**

Phoenixing has been driven primarily by regulatory asymmetry and competitive marketing pressures. Since new products can be launched without ministerial scrutiny, insurers have a strong incentive to "refresh" their portfolios to raise prices or segment risk. The creation of "Silver Plus" and other hybrid tiers has compounded this problem by blurring distinctions between coverage levels, making it easier for insurers to repackage benefits without meaningful changes. Once the loophole is closed, insurers are likely to shift towards fewer, more stable product lines and focus on legitimate product redesigns rather than rebranding for price increases. They may also rely more on annual, transparent premium adjustment processes instead of out-of-cycle launches. From a hospital perspective, these shifts are desirable, as they will improve contracting stability, facilitate long-term planning, and support continuity of care for patients who depend on Gold-level coverage.

**Any other matters the department should have regard to in relation to product phoenixing, the proposed legislative change and its implementation**

To reinforce the effectiveness of the reform, hospitals recommend establishing a public registry of PHI product openings and closures, managed by the Private Health Insurance Ombudsman. This registry should record product linkages, pricing and benefit changes, and insurers' stated reasons for introducing or retiring products. This transparency measure would allow consumers, hospitals, and regulators to trace changes over time and hold insurers accountable. Additionally, clear criteria should be established to determine when two products are "substantially similar," incorporating thresholds for benefit and price differences. Enforcement mechanisms should include graduated penalties, ranging from warnings to financial sanctions or temporary restrictions on new product approvals for repeat offenders. Finally, when a product is closed, insurers should be required to offer existing members a comparable alternative at no more than CPI-adjusted pricing, unless a higher premium has been approved through the public interest test. These measures, combined with stronger regulatory oversight and alignment with broader reforms being explored through the Private Health CEO Forum, will promote transparency, affordability, and long-term sustainability for both consumers and private hospitals.