The Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme

STATEMENT OF EXPECTATIONS FOR THE 2026 PRIVATE HEALTH INSURANCE PREMIUM ROUND

Context

To ensure the ongoing viability of private health services, it is my intention to continue to use the private health insurance premium round process to maintain the value proposition of private health insurance for consumers, and support an appropriate balance of market powers and equitable funding arrangements in the private healthcare industry. This will support the Australian Government's investment in the private healthcare sector of $7.8 billion on the private health insurance rebate in 2025-26 and 75% of the Medicare Benefits Schedule (MBS) fee for medical services delivered to private patients in hospital.

The private hospital sector has, and is expected to continue to face, a number of temporary and systemic challenges to its sustainability and capacity to contribute to the Australian health system. While parts of the sector have remained strong, there has been a reduction in profitability over time (from a profit margin of 5.1% in 2020-21 to -0.1% in 2023-24[1]) as costs have risen faster than revenue, and there has been a decline in investment across the sector.[2]

The proportion of hospital treatment premium revenue paid out as benefits by insurers (hospital benefits ratio) dropped from pre-pandemic levels of around 90% to a low of 83% in 2022-23. I note that the benefits ratio largely does not reflect insurers pandemic commitments givebacks to consumers (of $4.5 billion between March 2020 and 30 June 2024)[3] and net margins declined for both for-profit and not-for-profit insurers between 2018-19 and 2023-24 (by 0.3 and 0.6 percentage points, to 6.4% and 0.5%, respectively). [4]

Recent data shows a more positive turnaround, with healthcare service volumes largely recovered to pre-pandemic trends, albeit at a slower rate than expected and in lower-cost delivery settings. However, the information from private health insurers to the department earlier this year that indicated the industry hospital benefits ratio would approach around 87% for 2024-25 has not materialised. Rather, the hospital benefits ratio for 2024-25 is unchanged from the previous financial year, at 85.5%. This result is linked to a drop-off in hospital utilisation (PHI funded hospital admissions per insured person), declining by 0.3% in 2024-25.

It is encouraging that there has been continued steady growth (of 3.5% in 2024-25) in hospital benefits paid per episode, with this at least partly reflecting indexation arrangements between insurers and hospitals. However, it is worth noting that even if utilisation growth had been stable, the benefits ratio would have been substantially less than what was indicated when insurers were surveyed by the department in May 2025.

More strenuous efforts by insurers are needed to support the long-term viability of this essential part of our health system, including more equitable funding outcomes for the wide range of private

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[1] ABS Australian Industry, catalogue 8455.0.

[2] Private Hospital Sector Financial Health Check – Resources | Australian Government Department of Health, Disability and Ageing

[3] Private Health Insurer pandemic commitment monitoring reports | Australian Government Department of Health, Disability and Ageing

4 APRA Quarterly private health insurance statistics and APRA Quarterly private health insurance performance statistics, March 2025 quarter.

healthcare providers. I encourage private health insurers to give a higher priority to strengthening their core hospital insurance offering and prioritising support for the private hospital sector.

I encourage private hospitals and health insurers to collaborate closely, including through the Private Health Chief Executive Officer Forum, to ensure the private health sector remains financially sustainable in the short term, and to continue adapting and innovating to deliver efficient, contemporary hospital care into the future and take pressure off public hospitals.

Further, I note the Government's election commitment to legislate against product phoenixing. I have directed the department to develop legislative options to bring this into effect. Subject to the details being finalised and the passage of legislation, I intend to achieve this by amending the PHI Act to require Ministerial approval for premiums of new products (similar to the requirement to apply for premium changes). I note insurers would continue to be able to close or terminate products at any time in order to protect against prudential risk. Insurers will be strongly encouraged to apply for new product premiums through the annual Premium Round process. I will not be minded to approve applications made outside of this process except for under exceptional circumstances. While these details are being finalised, I expect insurers to cease practices that seek to deliberately circumvent the premium approval process and restrict consumer choice.

Expectations for the 2026 Premium Round

Under section 66-10 of the *Private Health Insurance Act* (the PHI Act), private health insurers must apply to me, as Minister for Health and Ageing, for approval of proposed changes to private health insurance premiums. The PHI Act requires that I approve these changes, unless I am satisfied that doing so would be contrary to the public interest.

Each application is assessed on its individual merits and I retain broad discretion to consider any relevant matters in determining whether a proposed change is contrary to the public interest.

I acknowledge that the private health insurance sector has called for greater certainty and transparency in the Premium Round assessment process. This communication represents a first step toward that goal.

I encourage the private healthcare industry to actively engage with my department to further improve this process. This will help ensure that the private healthcare system remains well-positioned to deliver high-quality care and effectively complement the role of the public system. Strengthening the collection and analysis of key operational and performance private hospital data would also better enable the department to work closely with the sector for the benefit of the Australian health system.

For the 2026 Premium Round (for requested changes to take effect on 1 April 2026), in considering whether a change would be contrary to the public interest, some of the matters I intend to have regard to are set out below. Inclusion of the following matters would be helpful in my assessment of applications against the public interest test.

1. **Consumer value and market integrity:** How the application supports value for consumers, including by keeping premium increases as low as possible, and contributes to a fair, transparent and competitive private health insurance market.
2. **Private hospital sector viability:** How the application will support the financial viability of the private hospital sector, including how it will support a continuous increase to the industry hospital benefits ratio during the 2026 and 2027 premium years (where relevant). This includes how insurers will use their funding models to incentivise hospitals to deliver more innovative and cost-efficient models of care and to reduce significant differences in private hospital profit margins across the case mix.

3. **Balance of consumer value and sector viability**: Whether the application appropriately balances consumer value, the financial viability of the private hospital sector and the ability of the insurer to meet its obligations to its members, taking into account the insurer's historical and projected financial performance. I will pay particular attention to benefits paid, business expenses, net margins, investment income, profit and capital levels, and dividend payouts (where applicable).
4. **Accuracy of previous projections**: Whether the financial performance projections (as outlined above) used to justify previously approved premium increases differed from actual outcomes, and whether the application adequately explains and accounts for any differences. For example, if benefits growth was lower than forecasted, how has the application factored in the unexpected gain for the insurer (i.e. how much of the additional margin was kept by the insurer and how much was used to support their members, such as through funding a lower requested premium increase, or to support the viability of private hospitals).

Issued by:
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