



Private Health Insurance 2027 Premium Round Application Form

Purpose

Private health insurers are required to use this 2027 Premium Round Application Form to seek approval from the Minister for Health and Ageing (Minister) for one or more of the following circumstances:

- If an insurer proposes to make a new product/product subgroup available (per section 66-8(5) of the *Private Health Insurance Act 2007* (PHI Act)) from 1 April 2027.
- If an insurer proposes to change the premium of a complying health insurance product/product subgroup (per paragraph 66-10 (1)(a) and 66-10 (5) of the PHI Act) from 1 April 2027.

Note: insurers are not required to seek Ministerial approval to make a designated change (defined in section 66-7 of the PHI Act) to a complying health insurance product (as per paragraph 66-10(1)(b) of the PHI Act) for designated changes intended to take effect prior to **2 April 2027**.

Submissions

Applications for the 2027 Premium Round can be submitted via the Department of Health, Disability and Ageing's (the department's) **Health Data Portal (the portal)**, a cloud-based file transfer system by **3pm Wednesday 11 November 2026**.

Access to the Portal has been provided to the nominated users for each insurer. To add or remove additional users, please provide details to PHIPremiumRound@health.gov.au.

The Australian Prudential Regulation Authority (APRA) will have access to the applications and may engage with contacts on any questions they have. APRA's role in relation to applications is to provide advice on potential adverse prudential outcomes for each insurer.

Direct any enquiries on the premium round application form to the department (PHIPremiumRound@health.gov.au) at the earliest opportunity to ensure sufficient time to respond.

Assessment of applications

All Premium Round applications are assessed by the department and APRA and are subject to approval by the Minister for Health and Ageing.

For all applications submitted in the approved application period (per section 66-8 of the PHI Act), Ministerial approval would be given unless it is considered by the Minister to be 'contrary to the public interest' (per subsections 66-8(5) and 66-10(5) of the PHI Act). If an application is rejected, the Minister must table the Minister's reasons for refusal in each House of the Parliament no later than 15 sitting days of that House after the refusal.



Australian Government

Department of Health, Disability and Ageing

The only exception to this is for applications for a decrease in the premium of a product, which must be approved by the Minister without consideration of the public interest.

The Minister may request further information about an application to assist the Minister in considering the application (per section 66-11 of the PHI Act). The Minister may also give notice to the insurer inviting them to further justify their application including through a resubmission (per section 66-12 of the PHI Act).

Confidentiality and Publication

The submitted premium application forms will be treated as **protected information** as defined by the *Private Health Insurance Act 2007* (PHI Act). The department may use or disclose the information provided where authorised or required by law, including Division 323 of the PHI Act and, where relevant, the *Privacy Act 1988*.

The department intends to publish on its website each insurer's historic and approved 2027 average premium price change, the industry average premium price change and a summary of approved new products.

Only highly aggregated or non-identifiable information will be made public. This may include the number of approved new products and average premiums or premium changes by jurisdiction, insured group, open/closed status or product tier.



The Premium Application Form

The PHI Act requires that applications to the Minister for premium approval must be in the approved form (sections 66-8(2) and 66-10(2)).

A written report and 5 templates (Template A, Template B, Template C, Template D and Template E) are collectively referred to as the premium application form. Optional covering letters will also be considered as part of the premium application form.

Template A allows insurers to detail the requested premiums for both new products/product subgroups and if the insurer proposed to change the premium under existing product subgroups. For the purposes of sections 66-8(1) and 66-10(1)(a) of the PHI Act, the premiums in Template A are for consideration by the Minister.

Per the PHI Act, designated changes can be made to an existing product without premium approval until and including 1 April 2027. That is, insurers are **not required** to seek approval for any changes to an existing product that may be considered a designated change and where a change to the premium, if any, is to take effect prior to 2 April 2027. However, while a proposed designated change will not require approval, the premium for the existing product with proposed changes to benefits will still require approval under section 66-10 of the PHI Act. Insurers are reminded that each application is assessed on its individual merit and the impact of any changes to a product on a proposed premium change may be considered.

In submitting the premium application form, please note:

- All products currently available and all new products expected to commence on or prior to 1 April 2027 should be included. The details of proposed new products/product subgroups may be provided on a best endeavours basis.
- A 'product' for this purpose is one that shares the same coverage and name, but combined across all states, co-payments and insured groups (e.g. family, single). Products with different excesses, coverage or name should be considered a different product.
- All information should be provided as instructed in this document.
- Data should align with information provided to APRA under the reporting standards.
- Pages should be numbered in the written report.
- The premium application form should **not** be submitted in PDF format.
- Only information that is relevant to the health insurance business is required.¹

The department and/or APRA will contact insurers to discuss applications that do not comply with the guidelines and requirements set out in this document.

¹ Other than Template B where data is collected at a Health Benefits Fund level.



2027 average premium increase

The 2027 average premium increase will be calculated from the premium as approved by the Minister in the 2026 premium round, regardless of whether this premium has been applied or not. The 2027 average premium increase will therefore not incorporate the premiums for new products approved by the Minister.

The written report

Applications for premium changes should include all information outlined below.

As a guide, an application which is consistent with the insurer's pricing targets and capital targets is expected to be no more than 20 pages and no more than 10 pages for the actuarial opinion.

Questions

Reference	Question	Guidance
1	Insurer name	Provide the name of the insurer as registered with APRA as at the premium application date.
2	Date(s) of effect for the proposed premiums	Provide the date(s) on which the proposed premiums are to take effect. Insurers are requested to implement the premium changes to existing products on 1 April 2027. Insurers may launch a new product/product subgroup at the approved premium at any date on or after the approved date of effect.
3	Summary statement	Option to answer this question by way of a covering letter OR as part of the written report. Insurers should provide an overview of proposed changes included in their application, including a summary of proposed new products and how the key drivers have resulted in the prices applied for and highlight any significant issues or key changes associated with the pricing or implementation approach. Insurers are also asked to provide details on any new planned termination of products for additional context on insurer activity.
4	New products/product subgroups	For proposed new products/product subgroups, insurers should provide the product specifications of the proposed new product/product subgroup and detail the rationale for opening the proposed new products/product subgroups.



Reference	Question	Guidance
5	Public Interest rationale	Insurers should provide justification for their application against the public interest test.
6	Consistency with pricing targets	Outline whether the premium application is consistent with the insurer's approach to managing insurance risks. This is to detail products that are currently, or forecast to be, outside of pricing targets and any remedial action planned over the forecast period. Insurers are expected to <u>demonstrate</u> whether <u>products</u> and the <u>fund</u> are aligned to the pricing targets. Insurers are also asked to outline products with a gross margin pricing target below other insurance business expense ratio, i.e. products that are targeting losses and to confirm whether any action is planned on these products.
7	Consistency with capital targets	Outline whether the capital projections outlined in Template B are consistent with the insurer's capital targets. This should detail any remedial action planned over the forecast period should the projections be below the targets.
8	Benefit growth	Outline the approach to forecasting benefits over the projection period. Commentary should provide an understanding of how benefit growth is forecast (including reference to factors driving average cost growth and utilisation rates) and why they are considered reasonable. This may include quantifying growth drivers and programs affecting benefit growth. Commentary should specifically cover the insurer's view on how the underlying future benefits have been affected by Government reforms including • Medicare Benefits Schedule changes Commentary may also cover matters, such as hospital contract indexation, health system resourcing, out-of-hospital care initiatives, or other programs aimed at reducing costs etc, changes in claiming behaviour and/or uncertainty over the forecast period.



Reference	Question	Guidance
9	Out-of-pocket costs	Provide commentary on the insurer's strategy and activities that are expected to impact out-of-pocket costs paid by policyholders. Out-of-pocket costs also include excesses and co-payments. Commentary should cover the insurer's position on: • arrangements, such as no and known gap agreements, to limit policyholder medical out-of-pockets • strategies and actions affecting customer decisions on excesses and copayments. Where possible, quantify the expected customer impact of these initiatives from 1 April 2027.



Reference	Question	Guidance
10	Pricing	Summarise drivers affecting the requested premiums. Commentary should include: • The extent that differences in recent experiences versus last premium round's assumption – (including benefits growth and other business expenses) have been accounted for in this year's application • Any additional commentary on benefit growth factored into pricing, not covered in section 8. • Any other drivers that have contributed to premium increases applied, changes in margins, capital and other strategies or material risks. • Impact of aligning the PHI Rebate for those aged 65 years and older with the general population from 1 April 2027. Outline the approach to factoring Risk Equalisation payments into premium pricing. Provide commentary on the target profit margins, including: • How margins are derived • Return on capital expectations and the extent to which they are met by margins • Margins realised historically (past 5 years). Provide commentary on how profits/surpluses serve members outside of the insurance benefits. If insurers have concerns with the attribution analysis in Template E, an alternative analysis may be provided, but should adequately cover the areas mentioned above.
11	Other business expenses	Provide commentary on the insurer's strategy and activities that are expected to impact other business expenses and whether this has an impact on the requested premium increase. This may include commentary on 'health-related expenses' and 'other business expenses' that benefit members separate to regular business as usual operations.
12	Consistency with Act and Rules	Provide a declaration that the premium changes are consistent with the <i>Private Health Insurance Act 2007</i> and <i>Private Health Insurance (Prudential Supervision) Act 2015</i>, and the associated Rules, as at the date submitted.



Reference	Question	Guidance
13	Actuarial opinion	Provide an opinion (and commentary where relevant) from the Appointed Actuary regarding whether the assumptions and forecasts are reasonable. The Appointed Actuary should specifically comment on assumptions on future drawing rate growth. Provide a comment on the reasonableness of the conversion factor values provided by the insurer in Template C. The Appointed Actuary may also comment on any matter he/she deems relevant to the premium application process.
14	Contact person	Provide the contact details of a primary contact person, and an alternative contact person. This should include: • name • position title • landline telephone number • mobile phone number • E-mail address.



Template A (Products)

- All complying health insurance products should be reported regardless of whether a change in premium is sought. That is, Template A should be completed for all products currently available and all proposed new products/product subgroups expected to commence on or after **1 April 2027**. Information should be provided for all product subgroups, even if some products have the same price (e.g., information should be provided for couple policies even if they are priced the same as family policies).
- All products should reflect the name, excesses, product code and premiums as they will appear in the Private Health Information Statements (PHIS) and Fund Rules from **1 April 2027**. If these details are not yet confirmed for proposed new products/product subgroups, insurers should provide indicative information in the application and provide updated information to the department once the details are confirmed.
- Ambulance Only policies should be included where they are complying health insurance products, and included in HRF601.
- Do not include Overseas Visitors Health Cover or Overseas Student Health Cover products.
- Do not create new categories as a substitute for drop down list options – select only options in the drop-down menu.
- Template A “number of policies” and “insured people” should be consistent with HRF601 for the **September 2026** quarter.
- If an insurer plans to terminate products, additional information is requested on the effective 2027 price of products that customers are to be migrated to. This will not be reflected in the headline increase, but rather to provide the Minister with visibility of the termination-migration effect.



Field Descriptions

Field	Data Entry Guidelines	Example
Column A - Insurer	Name of insurer.	
Column B - State	Select from the drop down list the State/Territory in which the product is available. This should be consistent with the risk equalisation jurisdiction for APRA reporting. Each State/Territory should be recorded separately (i.e. if the same product is available in multiple states, record in individual rows).	Drop down list: • NSW / ACT • NT • QLD • SA • TAS • VIC • WA
Column C - Product code PHIS ID	Enter in full the unique product identification code for the product, exactly as generated in the PHIS by privatehealth.gov.au (i.e. do not truncate by omitting insurer identifier component of code). Every unique PHIS ID should be included in its own row. This includes products that are closed, or have zero policies/people. Note: for proposed new products/product subgroups, enter on a best endeavours basis.	
Column D - Product name as at 1 April 2027	Enter the product name. If the name is duplicated across products, do not leave any rows blank, but instead enter the identical name for each product. This should be consistent with the information recorded in the PHIS for the product. Note: for proposed new products/product subgroups, enter on a best endeavours basis.	Gold Hospital Cover



Field	Data Entry Guidelines	Example
Column E - Product status as at 1 April 2027	Select from the drop-down list whether the product is: - Proposed New Product: New product planned to be open from 1 April 2027 (any proposed new products that the insurer is seeking premium approval for under section 66-8 of the PHI Act). - Open – Existing: Open already existing product as at 1 April 2026 that will continue to be open to new customers on 1 April 2027. - Open – New: Open and existing products that were opened (or intended to be opened) on or after 2 April 2026 that will continue to be open to new customers on 1 April 2027 - Closed – Closing: Product open on 1 April 2026 that the insurer intends to close by 1 April 2027. - Closed – Existing: Product that is closed to new customers as at 1 April 2026. - Terminating: Product planned for termination by 1 April 2027, with customers being migrated to alternative products. Note: the product status as at 1 April 2027 should be completed on a best endeavours basis based on available information as at 30 September 2026.	Drop down list: - Proposed New Product - Open – Existing - Open – New - Closed – Closing - Closed – Existing - Terminating
Column F – Is the proposed new	For proposed new products that are intended to replace a	



Field	Data Entry Guidelines	Example
product intended to replace a closing/terminating product? If yes, provide the PHIS code of the closing/terminating product	closing/terminating (or previously closed/terminated) product, insurers are asked to enter the PHIS code of the insurer's closing/terminating product. Otherwise, leave blank.	
Column G – For proposed new products, enter a comparator product identifier (either PHIS code or insurer and product name). Comparator product may be the insurer or competitor's product.	Enter a product identifier (either PHIS code or insurer and product name) of a comparator product that is similar to the proposed new product. If an insurer has provided a PHIS code in column F, column G may then be left blank and the product nominated in column F will be assumed to be the comparator. Insurers may choose to provide an alternative comparator. Comparators may be the insurer's own product or a competitor's product. If no comparator is nominated, insurers are asked to provide further detail on the product specifications (i.e. hospital and/or general treatment services) of the proposed new product/product subgroup (Question 4) in the written report.	
Column H - Product Coverage	Select only from the drop-down list: Hospital = Hospital treatment only (may include ambulance,	Drop down list: - Hospital - General - Combined



Field	Data Entry Guidelines	Example
	CDMP or hospital-substitute treatment) • General = General treatment only • Combined = Combined hospital and general treatment • General - Ambulance = Ambulance only	• General - Ambulance
Column I - Hospital category as at 1 April 2027	Select only from the drop-down list. This should be consistent with the information recorded in the PHIS for the product with that particular unique product identification code. Leave blank for general products.	Drop down list: • Gold • Silver Plus • Silver • Bronze Plus • Bronze • Basic Plus • Basic
Column J - Insured Group	Select only from the drop-down list. Enter information for each product subgroup separately even if different insured groups have the same price (e.g. include couples information in a separate row from family's information even if they have the same prices, if they have different PHIS's).	Drop down list: • ChildrenOnly • Couple • ExtendedFamily • ExtendedSingleParentFamily • Family • Single • SingleParentFamily
Column K - Maximum excess per admission	Enter the maximum excess per admission for the product. For example, where a product has an excess of \$0 for same-day admissions and \$250 for overnight admissions, the value entered should reflect the maximum excess per admission, i.e., \$250. For example, where a product has a maximum excess per admission of \$750, this would	\$250



Field	Data Entry Guidelines	Example
	previously have been entered as \$750 for a single and \$1,500 for a couple. The excess for this product should be entered as \$750 regardless of insured group.	
Column L - Annual co-payment as at 1 April 2027	Enter the maximum annual total co-payment amount for the product as at 1 April 2027 as a dollar amount or “no cap”. A dollar amount should report the maximum allowable annual total co-payment amount (this is an amount separate to Annual excess – see above). For example, enter \$500 if the co-payment is \$50 per admission for every admission up to a maximum of \$500 per year. If no cap exists, enter “no cap”.	\$500 or “no cap”
Column M - 2026 Monthly premium (\$) for products existing on 30 September 2026	Enter the approved 1 April 2026 price, regardless of whether this price has been applied or not. The 2027 average premium increase will be calculated from the base price as approved by the Minister in the 2026 premium round. Enter the price of all products opened between 1 April 2026 and 30 September 2026. This price should reflect the full price and exclude the rebate, LHC loadings, and discounts. For products that did not yet exist as at 30 September 2026 but are intended to be made available prior to 1 April 2027 and where the premium has not yet been approved through an out-of-	\$100.07



Field	Data Entry Guidelines	Example
	round application, the price should be completed on a best endeavours basis.	
Column N - 2027 Monthly premium (\$) as at 1 April 2027 - for all products (new and existing)	Enter the proposed new price per month for the product as at 1 April 2027, including for new products proposed to be launched from 1 April 2027. This price should reflect the full price and exclude the rebate, LHC loadings, and discounts. For terminating products, please enter the 2026 price.	\$101.67
Column O - Total number of people covered by this product as at 30 September 2026	Enter the total number of people covered by the policies comprising the insured group for the particular product as at 30 September 2026 (e.g. number of people covered by family policies for the product). Do not record single equivalent units (SEUs). Please leave this as 0 for proposed new products commencing from 1 April 2027.	2,000
Column P - Total number of policies covered by this product as at 30 September 2026	Enter the total number of policies comprising the insured group for the particular product as at 30 September 2026 (e.g. number of couples policies for the product). Do not record SEUs. For products that did not yet exist as at 30 September 2026 (including proposed new products from 1 April 2027) leave this as 0.	1,000
Column Q - Average age-based	The average age-based discount conversion factor should be	



Field	Data Entry Guidelines	Example
discount conversion factor 2026	identical to that applied in the 2026 premium round. 100% should be applied to products that did not have an age-based discount in 2026.	
Column R - Average age-based discount conversion factor 2027	The average age-based discount conversion factor applied to all policies on this product. This is only relevant to products where the age-based discount will be applied. 100% should be applied to products that do not have age-based discounts or for all new products. For example, if 100 people are on a product, and 10 people are eligible for a 2% age-based discount, the difference in monthly income when the discount is applied is 0.2%, therefore, the age-based discount conversion factor is 99.8%.	
Column S - Average age-based discount conversion factor net change	This is an automated field that calculates the 2026 age-based factor [Column Q] less the 2027 age-based factor [Column R]. This provides a net factor for 2027 calculations which will flow through to the insurer average premium change figure in Template C.	
Column T - Monthly premium revenue 2026	This is an automated field that calculates the 2026 monthly income from all policies on the product based on 2026 monthly premium [Column M] multiplied	



Field	Data Entry Guidelines	Example
	by the total number of policies covered by this product as at 30 September 2026 [Column P]. Because there will be zero policies in Column P for a proposed new product, this field will be zero for all proposed new products.	
Column U - Premium increase 2027 (\$)	This is an automated field that calculates the dollar value of the premium change between the 2027 monthly premium price [Column N] and the 2026 premium price [Column M]. For new products this field will be automatically flagged as a 'new' product. For terminating products this field will be automatically flagged as "terminating".	
Column V - Premium increase 2027 (%)	This is an automated field that calculates the percentage change between the 2027 monthly premium price [Column N] and the 2026 premium price [Column M]. For proposed new products this field will be automatically flagged as a 'new' product. For terminating products this field will be automatically flagged as "terminating".	
Column W - Monthly premium revenue 2027	This is an automated field that calculates the 2027 monthly premium revenue for all policies on the product based on the 2027 monthly premium [Column N] multiplied by the total number of policies covered by this	



Field	Data Entry Guidelines	Example
	product as at 30 September 2026 [Column P]. Because there will be zero policies for a proposed new product, this field will be zero for all proposed new products. For terminating products, the 2026 monthly premium will be used in place of the 2027 monthly premium.	
Column X - 2027 Monthly effective average premium (\$) as at 1 April 2027 of products to be migrated to (TERMINATING PRODUCTS ONLY)	For terminating products: enter the weighted average price per month as at 1 April 2027 of products that policy holders are planned to be migrated to. Prices used should be consistent with Column N. Insurers may opt to use product mix weights set nationally or at a more granular State/insured group level. Prices should be of the same policy attributes - State/insured group/excess, unless reasonable grounds to vary, e.g. moving to a different excess level. Leave blank if the product is not terminating.	If 10 policy holders were being migrated and: • 6 were being migrated to a policy with a new monthly premium of \$400 • 4 were being migrated to a policy with a new monthly premium of \$300 The average monthly premium would be \$360 $[(\\$400 * 6 + \\$300 * 4) / 10]$
Column Y- Monthly premium revenue (including terminating products) 2027 Based on Apr27 monthly premium x number of policies as at 30 September 2026	This is an automated field that calculates the 2027 monthly premium revenue for all policies on the product based on the 2027 monthly premium (using information from Column N for non-terminating products and Column X for terminating products) multiplied by the total number of policies covered by this product as at 30 September 2026 [Column P]. Because there	



Field	Data Entry Guidelines	Example
	will be zero policies for a proposed new product, this field will be blank for all new products. For terminating products, this will reflect the additional premium revenue received when policies are migrated to the proposed new product.	
Column Z- Effective premium increase 2027 (%)	This is an automated field that will equate to the Premium increase 2027 (%) [Column V] for non-terminating products. Terminating products will be calculated as the percentage change of the premium change between the 2027 monthly effective premium price [Column X] and the 2026 premium price [Column M].	



Template B (Financials)

- Template B reflects the APRA capital and reporting framework effective as of 1 July 2023.
- Actual data submitted under Template B must be consistent with actual data submitted under the APRA reporting standards. Notwithstanding this, insurers must note the following differences:
 - Template B requests monthly data whereas the APRA reporting standards request quarterly data.
 - Data must be entered in thousands of dollars (\$'000) under Template B (with the exception of Hospital and General Treatment SEUs where the data must be entered in whole numbers). However, under the APRA reporting standards via APRA Connect, data are submitted in whole dollars.
- Data items highlighted in **bold** and *italics* within the tables below are defined in the APRA reporting standards.
- For items relating to balance sheet (APRA basis), HPS 340 insurance liabilities, prescribed capital amount (PCA) and capital base / target capital, insurers are only required to complete the forecasts on a quarterly basis.
- Insurers must provide the respective actual data items for the September 2026 month (and the October 2026 month where possible), and the respective forecast data items for each month thereafter. Insurers must also provide actual monthly data from April 2025 for specified items (HIB premiums, claims, other business expenses and SEU's). These figures should align in aggregate with data submitted for quarterly and annual APRA reporting.
- Data must be reported at a Health Benefits Fund level. Where applicable, data items must be aggregated across categories to calculate the amount for a Health Benefits Fund.
- Insurers are only required to complete the white cells. Grey cells will automatically calculate.
- The PCA is a formulaic driven line item which accounts for the minimum PCA of \$5 million as per Prudential Standard HPS 110 Capital Adequacy (HPS 110) paragraph 24.
- Cells in Template B without a value should have a '0' inserted and not be left blank.
- No additional columns or rows are to be inserted into Template B.



Items under insurance performance and balance sheet – APRA basis

Data item	Definition
HIB Premium Revenue	This item aligns with accrued premium reported under <i>Reporting Standard HRS 101.0 Regulatory Income Statement – Supplementary Information</i> (HRS 101.0).
Claims Incurred	This item aligns with claims incurred amount reported under HRS 101.0.
Net Risk Equalisation Special Account Amount	This item aligns with net RETF amount reported under HRS 101.0.
State Ambulance Levies	This item aligns with state ambulance levies reported under HRS 101.0.
Other Insurance Business Expenses – HIB	This item aligns with other business expenses amount for health insurance business (HIB) reported under HRS 101.0.
Gross of reinsurance HRIB Premium Revenue	This item aligns with the gross accrued premium for health-related insurance business (HRIB) reported under HRS 101.0
HRIB Premium Revenue	This item aligns with the amount calculated after deducting reinsurance premiums ceded amount from gross accrued premium for health-related insurance business (HRIB) reported under HRS 101.0
HRIB Insurance Claims	This item aligns with the amount calculated after deducting reinsurance recoveries amount from gross claims incurred amount for health-related insurance business reported under HRS 101.0
Other Insurance Business Expenses – HRIB	This item aligns with other business expenses amount for health-related insurance business reported under HRS 101.0.
Net Other Operational Revenue (Include Health-Related Business Non-Insurance)	This item aligns with the amount calculated after deducting other business expenses amount for health-related business non-insurance from the sum of health-related business non-insurance revenue amount and net other operational revenue amount. The relevant data items are reported under HRS 101.0.



Data item	Definition
Investment Income Amount	This item aligns with investment income amount reported under HRS 101.0.
Gains/Losses on Investments Amount	This item aligns with gains/losses on investments amount reported under HRS 101.0.
Hospital SEUs (at months end)	This item aligns with Single Equivalent Units (fund) count reported under <i>HRS 115.0 Insurance Risk Charge</i> (HRS 115.0). These values must be reported in whole numbers.
General treatment SEUs (at month end)	General treatment SEUs reported are to exclude Hospital-Substitute, CDMP and Hospital-linked Ambulance Treatment. This should be calculated consistent with that of Hospital SEUs the values must be reported in whole numbers.
Total Assets (Excluding DTAs, Total Intangible Assets And Goodwill, And AASB 17 Insurance And Reinsurance Contracts Asset)	This item aligns with the amount calculated after deducting the following items from total assets : • Total deferred tax assets; • Total intangible assets and goodwill; • Insurance contract assets; and • Reinsurance contract assets. The relevant data items are reported under <i>HRS 300.0 Statement of Financial Position</i> (HRS 300.0).

Items under capital standards

Data item	Definition
Outstanding Claims Liability At 75th Probability Of Adequacy	This item aligns with OCL at 75th probability of adequacy calculated under HRS 115.0.
Premiums Liability At 75th Probability Of Adequacy (HIB)	This item aligns with PL at 75th probability of adequacy calculated under HRS 115.0 for health insurance business.



Data item	Definition
Premiums Liability At 75th Probability Of Adequacy (HRIB)	This item aligns with <i>PL at 75th probability of adequacy</i> calculated under HRS 115.0 for health-related insurance business.
Risk Equalisation Transfers At 75th Probability Of Adequacy	This item aligns with the amount calculated after deducting <i>unbilled gross deficit amount</i> from the sum of the following items. • Unbilled calculated deficit amount; • Billed risk equalisation special account liability amount; and • Risk margin at 75th POA – risk equalisation transfers amount. The relevant data items are reported under HRS 115.0.
Individual Other Insurance Liability At 75th Probability Of Adequacy	This item aligns with <i>individual other insurance liability at 75th POA amount</i> reported under HRS 115.0.
Deferred Claims Liability At 75th Probability Of Adequacy	This item aligns with <i>DCL at 75th probability of adequacy (POA) amount</i> reported under HRS 115.0
Outstanding Claims Liabilities Risk Charge	This item aligns with <i>Outstanding Claims Liabilities Risk Charge</i> reported under <i>HRS 110.0 Prescribed Capital Amount</i> (HRS 110.0).
Premiums Liabilities Risk Charge	This item aligns with <i>Premiums Liabilities Risk Charge</i> reported under HRS 110.0.
Risk Equalisation Risk Charge	This item aligns with <i>Risk Equalisation Risk Charge</i> reported under HRS 110.0.
Other Insurance Liabilities Risk Charge	This item aligns with <i>Other Insurance Liabilities Risk Charge</i> reported under HRS 110.0.
Future Exposure Risk Charge (HIB)	This item aligns with <i>Future Exposure Risk Charge (HIB)</i> reported under HRS 110.0.



Data item	Definition
Future Exposure Risk Charge (HRIB)	This item aligns with <i>Future Exposure Risk Charge (HRIB)</i> reported under HRS 110.0.
Deferred Claims Liability Risk Charge	This item aligns with <i>Deferred Claims Liability Risk Charge</i> reported under HRS 110.0.
Asset Risk Charge	This item aligns with <i>Asset Risk Charge</i> reported under HRS 110.0.
Asset Concentration Risk Charge	This item aligns with <i>Asset Concentration Risk Charge</i> reported under HRS 110.0.
Operational Risk Charge	This item aligns with <i>Operational Risk Charge</i> reported under HRS 110.0.
Aggregation Benefit	This item aligns with <i>aggregation benefit</i> reported under HRS 110.0.
Tax Benefits	This item aligns with <i>tax benefits</i> reported under HRS 110.0.
Adjustments To Prescribed Capital Amount As Approved By APRA	This item aligns with <i>adjustments to prescribed capital amount as approved by APRA</i> reported under HRS 110.0. Only adjustments approved by APRA should be reported in this data item, consistent with the definition in HRS 110.0. Please do not report the difference between the minimum PCA and the calculated PCA in this item. Insurers electing to participate in the transitional arrangements described in HPS 110 Attachment A should report the adjustment to the PCA under this item.
Capital Base	This item aligns with <i>capital base</i> calculated under <i>HRS 112.0 Determination of Capital Base</i>. Insurers electing to participate in the transitional arrangements described in <i>Prudential Standard HPS 112 Capital Adequacy: Measurement of Capital</i> Attachment G should report the capital base after applying the transitional adjustment.
Dividends Declared Or Paid	This item aligns with <i>dividends declared or paid</i> reported under HRS 101.0. Report this item as a positive value.



Data item	Definition
Retained Earnings Movements Other Than Profit / Loss After Tax and Dividends Declared or Paid	This item is all movements in retained earnings movement within the Health Benefits Fund excluding movements due to the following items reported under HRS 101.0. • Profit / loss after income tax attributable to members of the company; and • Dividends declared or paid. Please only report those movements that impact the capital base. Report this as a positive value where it would result in an increase in retained earnings. Report this as a negative value where it would result in a decrease in retained earnings.
Share Capital Injections	This item is any share capital injections made into the Health Benefits Fund (e.g. from the parent). Report this item as a positive value.
Share Capital Movements Other Than Share Capital Injections	This item is all movements in share capital movement within the Health Benefits Fund other than share capital injections (e.g. share capital reductions). Please only report those movements that impact the capital base. Report this as a positive value where it would result in an increase in share capital. Report this as a negative value where it would result in a decrease in share capital.
Target Capital – upper bound	Insurers that use a range for its target capital should report the upper bound of the range. Insurers that use a single figure for its target capital should report the figure in the lower bound field and zero here.
Target Capital – lower bound	This item aligns with target capital amount reported under <i>HRS 104.0 Forecasts and Targets</i>. Insurers that use a range for its target capital should report the lower bound of the range.



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Data item	Definition
	Insurers that use a single figure for its target capital should report the figure here.



Template C (Snapshot)

- Insurers are only required to complete the white cells. Grey cells will automatically calculate.
- Rate Protection Conversion Factor (%) will convert Excluding Rate Protection (%) into Including Rate Protection (%). To be calculated as per prior years.
- Proposed changes to benefits, should include an estimated cost or saving as a percentage of total HIB premium revenue (in the 12 months from 1 April). Savings should be stated as a negative amount as a percentage of total HIB premium revenue. For changes to benefits due to product changes, details should be included in the Product Changes section of the table. Product changes may be grouped as the insurer sees fit.
- The department intends to publish the insurer average premium rate change including age-based discount and rate protection.



Template D (Various)

Product gross margins

- Insurers are asked to provide actual and forecast gross margins, based on past and proposed price increases, for hospital products (by product tier) and general treatment products, for the years commencing:
 - 1 April 2025 (actual)
 - 1 April 2026 (projected in the approved 2026 premium round application, and current projection)
 - 1 April 2027 (current projection) and
 - 1 April 2028 (current projection).
- Risk equalisation should include gross deficit and calculated deficit. All relevant allocations should be done on a best endeavours basis.
- Gross margins by Hospital product tier are inclusive of Plus products.
- If the product is a combined product, margins are to be included separately for the hospital component and general treatment component of the product in the categories above.
- Insurers are asked to outline in the submission any assumptions on product and membership mix underpinning the forecasts.

Target margins

Insurers are asked to provide their target HIB gross and net margins information (leaving blank where not available). Where targets are set for different segments of business, insurers are requested to provide aggregated figures for hospital, general treatment and aggregate HIB weighted using premium revenue for the year commencing 1 April 2027.

This information will allow the department to assess insurer performance against pricing policy.

Migration impact

Where insurers plan to migrate policyholders between products, insurers are asked to report the expected Gross Margin (\$) impact of the movement. The calculation should reflect both changes in premium received, relative to 2027 Monthly Premium reported in Template A, and changes in claims net of risk equalisation to reflect changes in coverage between products. Where possible, migration impacts should also consider policyholder terminations. The amount should be aggregated for all planned migrations.

Products below targets

Insurers are asked to identify products that achieved below the product's gross margin target percent. This can be margin from the last financial year or in the 12 months to 30 September 2026. The table asks for the HIB premium revenue for all these products divided by total HIB premium revenue for the insurer.



A 'product' for this purpose is one that shares the same coverage and name, but combined across all states, co-payments and insured groups (e.g. family, single). Products with different excesses, coverage or name should be considered a different product.

For example: a product 'Gold \$500' excess single Victoria, would be combined with 'Gold \$500' excess couple NSW. This would be combined with the offering in other states for Gold \$500 and all insured groups. However, Gold \$250 excess and Gold \$500 excess would be separate products. Similarly, if an insurer has multiple Gold products at \$500 excess with different names they should be considered different products. For example, Gold product A \$500 and Gold product B \$500 are to be considered different products.

Insurers that do not have targets at a product level are asked to apply the fund's overall gross margin target percent as the gross margin target percent for each product.

Insurers that do not have a gross margin target percent at a fund level are asked to identify products with a net margin below 0% i.e. loss-making products.

Insurers are asked to confirm whether the insurer has a gross margin target percent for the fund and at a product level in the application.

Largest products below target – by HIB premium revenue

Insurers are asked to identify the 10 largest products by HIB premium revenue that have:

- actual gross margin below the gross margin target percent; OR
- actual gross margin less than the expense ratio (previously referred to as management expense ratio). That is, the products making losses.

This is the gross margin for the products in the last financial year, or in the 12 months to 30 September 2026.

The forecast gross margins for the year commencing 1 April 2027 and 1 April 2028 are designed to align with the table on Hospital Product Margins described above.

Guidance for interpreting products and for insurers that do not have targets at a product or fund level can be found under 'Products below target' above.



Template E (Attribution)

Information is sought to inform department advice that uses a consistent attribution analysis of the requested premiums across insurers. Template E also provides transparency of how the department is analysing these standardised inputs, while noting that this analysis is considered in the broader context with each application assessed on its individual merits.

This template includes free-text fields allowing insurers to provide additional attribution factors and clarifying commentary for the department's consideration should the resulting analysis generate results contrary to an insurer's view. If insurers have concerns with the analysis in Template E, they may choose to submit an alternative attribution analysis in the Written Report.

Insurers are only required to complete the white cells, noting some are optional fields (labelled 'as required' or 'optional'). Grey cells will automatically calculate.

Required reporting periods

'Actual' vs expected – years commencing April 2025 and April 2026

Insurers are asked to report 'actuals' vs expected experience over the premium years commencing April 2025 and April 2026 for benefits drawing rate growth and other business expenses ratio. "Expected (approved PR26)" relates to insurer assumptions for this period from last year's approved premium round. 'Actuals' is the latest central estimate for this period, labelled as "'Actuals' (this application)" noting that it may comprise of both recent actual and updated forecast data.

Forecast assumptions – year commencing April 2027.

Insurers are asked to report latest expected assumptions for benefits drawing rate growth and other business expenses ratio over the premium year commencing April 2027. Growth rates should be against 'actuals', as described above.

Input fields

Net benefits drawing rate growth

Net benefits drawing rate growth reflects underlying growth in benefits, after net risk equalisation effects, per policy unit (typically SEU) and should *exclude* the impact of product mix changes for consistency with the premium change reflected in Template A. Growth rates are the year-on-year changes in drawing rates.

Fields available for input are:

- Hospital treatment net benefits drawing rate growth, including net risk equalisation (gross deficit less calculated deficit), split into the following benefit-weighted components if available:
 - Hospital benefits drawing rate growth, split into:
 - Utilisation (e.g. hospital episodes per policy unit) growth



- Indexation (e.g. benefits per episode) growth, including net risk equalisation
- Medical benefits drawing rate (e.g. benefits per policy unit) growth, including net risk equalisation
- Prescribed List benefits drawing rate (e.g. benefits per policy unit) growth, including net risk equalisation.

Aggregation of hospital benefits and net risk equalisation means that hospital treatment net benefits drawing growth is effectively a weighted average of net benefits (including gross deficit recoveries) drawing rate growth and average calculated deficit growth. Insurers should include any commentary where changes in risk equalisation effects are expected to have a material impact on their underlying net benefit growth.

- General treatment benefits drawing rate growth.

The department's preference is for chronic disease management programs and hospital-substitute benefits to be included with hospital benefits. However, consistency of data across time periods is of greater importance, and inclusion with general treatment is not expected to materially impact results.

Other business expenses ratio

Other business expenses ratio assumptions should be provided consistent with APRA reporting.

Attribution of premium rate change

The attribution analysis attempts to link the insurer headline premium change to underlying drivers based on data provided. Insurers are asked to provide commentary (or provide reference to the relevant section of the Written Report) as required, including any concerns the insurer has with the analysis. Key attribution components are:

- Actuals vs Expected – Recent actual experience of benefits growth and expenses versus expected from last year's approved premium increase application, calculated based on the information provided in the inputs table. Whilst variations do not automatically translate into higher or lower premium increases, insurers should specify how the variation is reflected in the 2027 premium application.
- Underlying aggregate net benefit drawing rate growth – calculated based on the component information provided in the above table.
- Migration impact – the revenue effect of terminating products and policies being migrated to other products. Any benefit impacts of migrations should be factored into benefit assumptions.
- Other expense ratio change should reflect any changes in next year's ratio compared with the current premium year.
- Other margin factors – other factors which materially affect insurer margins, and may include changes to prudential capital and risk adjustments. Insurers are requested to



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provide commentary (or a reference to the relevant section of the Written Report) for these factors.

- Residual – Insurers should provide commentary where the attribution residual is material, indicating contributing factors.



Avoiding Data Issues and Resubmissions

Each year a number of insurers are asked to resubmit applications due to incorrectly completing the approved form or for data issues. To avoid these in the coming round, insurers are asked to be particularly vigilant of data issues that have historically resulted in insurers being asked to resubmit.

To ensure each application does not contain data issues it is requested insurers check the following before submitting:

- The Excel spreadsheet does not contain links to other files.
- Cells surrounding the template are blank. Cells outside of the requested fields do not have checking or verification calculations.
- Changes to benefits in Template C that result in savings are expressed as a negative.
- Cells requesting a number have a number inserted and not text. Similarly, cells with a number have not been formatted to 'text'.
- The formula cells have not been edited by the insurer.
- Data entered by the insurer should be values and not include calculations.
- Compliance checks are routinely carried out to ensure premiums approved by the Minister in the premium round process reflect the corresponding PHIS. Please ensure that accurate PHIS Product IDs are provided along with the new premium price requested for each product.