



2023 Private Health Insurance Premium Application Form

Submissions

Please direct queries regarding the premium application form to phi@health.gov.au.

Applications should be submitted via **SecureDoc**, a cloud-based APRA owned file transfer system by **3pm, 15 November 2022**. SecureDoc access will be provided to the premium round primary and secondary contacts. If access is required for additional contacts in order to submit applications, please provide details to phi@health.gov.au by 14 October 2022.

Confidentiality and Publication

The submitted premium application forms will be treated as **protected information** as defined by the *Private Health Insurance Act 2007*.

The Department of Health and Aged Care intends to publish on its website each insurer's average premium price change and the industry average premium price change.

Only highly aggregated or non-identifiable information will be made public, such as average premium changes in jurisdictions or by insured groups.



The Premium Application Form

Section 66-10 of the *Private Health Insurance Act 2007* (the Act) provides that a private health insurer that proposes to change the premiums charged for a complying health insurance product must apply to the Minister for approval of the change:

- a. in the approved form; and
- b. at least 60 days before the day on which the insurer proposes the change to take effect.

A written report and 4 templates (Template A, Template B, Template C and Template D) 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 details the premium changes for each complying health insurance product. For the purposes of s66-10 of the Act, the changes to the premiums in Template A are the changes for consideration by the Minister. The approved changes are the individual changed amounts for each product or product sub-group in Template A.

The premium application form will be assessed by the Department of Health (Health) and the Australian Prudential Regulation Authority (APRA).

In submitting the premium application form, please note:

- New products which have been introduced between 1 April 2022 and 30 September 2022 should be included.
- All information should be provided as instructed in this document.
- Data should align with information provided to APRA, notably HRF601 and HRF602.
- 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.

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

2023 Average premium increase

The 2023 average premium increase will be calculated from the premium as approved by the Minister for Health in the 2022 premium round, regardless of whether this premium has been applied or not.

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 philosophy and capital management plan 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 premium change effect	Provide the date(s) on which the premium change(s) are to take effect. It is preferable for insurers to implement a date of effect of 1 April.
3	Summary statement	Option to answer this question by way of a covering letter OR as part of the written report. Summarise 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.
4	Consistency with pricing philosophy	<p>Outline whether the premium application is consistent with the insurer's pricing philosophy.</p> <p>This should detail products that are currently, or expected to be, outside of the pricing philosophy and any remedial action planned over the forecast period. Given COVID-19, insurers should outline whether the insurers philosophy and appetite for potential remedial action has been impacted by the environment.</p> <p>Insurers are expected to demonstrate whether or not products and the fund as a whole are aligned to the pricing philosophy.</p>
5	Consistency with capital management plan	<p>Outline whether the capital projections outlined in Template B are consistent with the insurer's capital management plan. This should detail any remedial action planned over the forecast period.</p> <p>For insurers that choose to include forecasts of the prudential capital amount (PCA) and capital base under the new capital standards, outline the simplifications used.</p>
6	Benefit growth	<p>Outline the approach to forecasting benefits over the projection period. Commentary should provide an understanding of how benefits were forecast and why they are considered reasonable.</p> <p>Commentary should specifically cover the insurer's view on:</p> <ul style="list-style-type: none">• Underlying benefit growth since COVID-19 started.• Future underlying benefit growth over the projection period.• Impacts of COVID-19 uncertainty on the forecast period.



Reference	Question	Guidance
		<ul style="list-style-type: none">• Whether the use of medical services or policyholder behaviour has changed over COVID-19.• How the underlying future benefits have been affected by Government reforms including:<ul style="list-style-type: none">○ Medicare Benefits Schedule changes.○ Prostheses reforms. Include commentary on how current year projections of savings differ to prior projections of savings for the same period, if applicable. For example, projections may have changed due to new information. Also outline how any projected savings will be passed on to policyholders.○ Dependents reforms (including how the insurer is implementing the reform, the maximum age of dependants and expected increase in participation).
7	Out-of-pocket costs	<p>Provide commentary on excesses, copayments and medical out-of-pockets expected to be paid by policyholders.</p> <p>Commentary should cover the insurer's view on:</p> <ul style="list-style-type: none">• Arrangements to limit medical out-of-pockets; and• The impact of co-payments and excesses on premiums. <p>To the extent possible, quantify these contributions by reference to recent data for a defined period (for example, the 12 months from 1 April 2021 to 31 March 2022).</p>
8	Pricing	<p>Outline any other drivers that have contributed to the prices applied for. This may include the impact of cost drivers such as hospital and medical specialist contract indexation, out of hospital care initiatives, or other programs aimed at reducing costs, other strategies or material risks. Specifically, insurers are asked to comment on how COVID-19 affects the prices applied for.</p> <p>Outline the approach to factoring Risk Equalisation (RE) payments into premium pricing, by product tier. This may include detailing what percentage of the price is attributable to RE payments and providing commentary on impacts on each product tier.</p>
9	Consistency with Act and Rules	<p>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.</p>



Reference	Question	Guidance
10	Actuarial opinion	<p>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 given the uncertainties of COVID-19.</p> <p>The Appointed Actuary may also comment on any matter he/she deems relevant to the premium application process.</p> <p>Provide a comment on the reasonableness of the conversion factor values provided by the insurer in Template C and the assumptions used to estimate the impact of the dependants reform in Template D.</p>
11	Contact person	<p>Provide the contact details of a primary contact person, and an alternative contact person. This should include:</p> <ul style="list-style-type: none">• name• position title• landline telephone number• mobile phone number• E-mail address.



Template A (Products)

- All products should be reported regardless of whether a change in premium is sought.
- Template A should be completed for all products currently available and all new products expected to commence on or prior to **1 April 2023**.
- All products should reflect the name, excesses, and premiums as they will appear in the PHIS and Fund Rules from **1 April 2023**.
- Ambulance Only policies should be included where they are complying health insurance products, and included in HRF601.
- Information should be provided for all products, even if some products have the same price (i.e. information should be provided for couple policies even if they are priced the same as family policies).
- 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 2022** quarter.
- Products listed in all templates should be identified with a unique ‘Product Code’ identifier. This should be the PHIS ID.
- If an insurer plans to terminate products from **1 April 2023**, the 2023 price should be identical to the 2022 price.
- **ANNUAL CO_PAYMENTS** (column J) to be entered as a dollar amount or as “no cap”. A dollar amount should report the **maximum** allowable **annual total** co-payment amount (this is an amount separate to ANNUAL EXCESS).
- **2022 MONTHLY PREMIUM (\$)** is the approved 1 April 2022 price, regardless of whether this price has been applied or not. The 2023 average premium increase will be calculated from the base price as agreed by the Minister for Health in the 2022 premium round, regardless of whether this price has been applied or not.
- The age-based discount conversion factor at Column O should be identical to that identified in the 2022 premium round. If the discount did not apply to the product, the factor will be 100 per cent.
- The age-based discount conversion factor at Column P of Template A is only relevant to products where the aged-based discount will be applied.
 - If the discount does not apply to the product, the factor will be 100 per cent.
 - If 100 people are on a product, and 10 people are eligible for a 2 per cent aged-based discount, the difference in monthly income when the discount is applied is 0.2 per cent, therefore, the aged-based discount conversion factor is 99.8 per cent.
- The age-based discount conversion factor at Column Q of Template A will calculate the change in the aged based discount. The figures in Column Q flow through to the insurer average premium change figure in Template C.



Field Descriptions

Field	Data Entry Guidelines	Example
Insurer	Name of insurer.	
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: <ul style="list-style-type: none">• NSW / ACT• NT• QLD• SA• TAS• VIC• WA
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). This includes products that are closed, or have zero policies/people.	
Product name as at 1 april 2023	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.	Gold Hospital Cover
Product status as at 1 april 2023	Select from the drop down list whether the product is: <ul style="list-style-type: none">• Open and is a New Product to the market.• Open already Existing product.• Closed – Closing, if the insurer plans to close the product anytime between 1 April 2022 to 31 Mar 2023.• Closed prior to 1 April 2022 – Existing.	Drop down list: <ul style="list-style-type: none">• Open – New Product• Open – Existing• Closed – Closing• Closed – Existing• Terminating



Field	Data Entry Guidelines	Example
	<ul style="list-style-type: none"> Terminating, if planning to terminate the product prior to 1 April 2023 with customers being migrated to alternative products. 	
Product Coverage	Select only from the drop down list.	Drop down list: <ul style="list-style-type: none"> Hospital = Hospital treatment only General = General treatment only Combined = Combined Hospital and General Treatment General Ambulance = AmbulanceOnly
Hospital category as at 1 april 2023	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: <ul style="list-style-type: none"> Gold Silver Plus Silver Bronze Plus Bronze Basic Plus Basic
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: <ul style="list-style-type: none"> ChildrenOnly Couple ExtendedFamily ExtendedSingleParentFamily Family Single SingleParentFamily 3+Adults
Annual excess as at 1 april 2023	Enter the amount of the excess for the product as at 1 April 2022. This is the maximum annual excess for the policy. For example, \$500 should be entered if the excess is \$250 per admission per	\$500



Field	Data Entry Guidelines	Example
	person but limited to a maximum of \$500 per year. This should be consistent with the information recorded in the PHIS for the product with that particular unique product identification code.	
Annual co-payment as at 1 april 2023	Enter the maximum annual total co-payment amount for the product as at 1 April 2023. 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”
2022 Monthly premium (\$)	Enter the approved 1 April 2022 price, regardless of whether this price has been applied or not. Enter the price of all products introduced between 1 April 2022 and 30 September 2022. This price should reflect the full price and exclude the rebate, LHC loadings, and discounts. For new products commencing on 1 April 2023, please leave blank.	\$100.07
2023 Monthly premium (\$) as at 1 april 2023 - for all products (new and existing)	Enter the proposed new price per month for the product as at 1 April 2023, including for new products. This price should reflect the full price and exclude the rebate, LHC loadings, and discounts. For products terminating by 1 April 2023, please enter the 2022 price.	\$101.67
Total number of people covered by this product	Enter the total number of people covered by the policies comprising the insured group for the particular product as at 30 September 2022 (e.g. number	2,000



Field	Data Entry Guidelines	Example
as at 30 september 2022	of people covered by family policies for the product). Do not record SEUs. Please leave blank for new products commencing on 1 April 2023.	
Total number of policies covered by this product as at 30 september 2022	Enter the total number of policies comprising the insured group for the particular product as at 30 September 2022 (e.g. number of couple's policies for the product). Do not record SEUs. Please leave blank for new products commencing on 1 April 2023.	1,000
Average age-based discount conversion factor 2022	The average aged-based discount conversion factor applied in the 2022 premium round should be applied. 100% should be applied to products that did not have an age-based discount in 2022.	
Average age-based discount conversion factor 2023	The average aged-based discount conversion factor applied to all policies on this product. 100% should be applied to products that do not have age-based discounts or for all new products.	
Average age-based discount conversion factor net	This is an automated field that calculates the 2022 aged-based factor less the 2023 aged-based factor. This provides a net factor for 2023 calculations.	
Monthly income from product	This is an automated field that calculates the 2022 monthly income from all policies on the product based on 2022 monthly premium in column K multiplied by the total number of policies covered by this product as at 30 September 2022 in column N. Because there will be zero policies in column N	



Field	Data Entry Guidelines	Example
	for a proposed new product, this field will be zero for all new products.	
2023 premium increase (\$)	This is an automated field that calculates the dollar value of the premium change between the 2023 monthly premium price and the 2022 premium price. For new products this field will be automatically flagged as a 'new' product. For terminating products this field will be automatically flagged as "terminating".	
2023 Premium increase (%)	This is an automated field that calculates the percentage change of the premium change between the 2023 monthly premium price and the 2022 premium price. For new products this field will be automatically flagged as a 'new' product. For terminating products this field will be automatically flagged as "terminating".	
2023 Monthly income from product	This is an automated field that calculates the 2023 monthly income for all policies on the product based on the 2023 monthly premium multiplied by the total number of policies covered by this product as at 30 September 2022. Because there will be zero policies for a proposed new product, this field will be zero for all new products.	
Estimated migration of people due to dependent reform over the 12 months	Estimate the number of people included in "TOTAL NUMBER OF PEOPLE COVERED BY THIS PRODUCT as at 30 September 2022 (Leave blank for new products commencing on 1 April 2023)" that will migrate as a result of the dependents reform. This number should reflect a movement for either part or all of the forecast	-100 +100 0



Field	Data Entry Guidelines	Example
<p>from 1 april 2023</p>	<p>contribution income 12 month period, therefore this may be a non-integer.</p> <p>For example:</p> <ul style="list-style-type: none"> • One person migrating for 12 months: -1 / +1 • One person migrating for six months: -0.5 / +0.5 <p>Enter zero where there are no movements.</p> <p>If impacts were reported last year, do not double-count in this year’s application.</p>	
<p>Estimated migration of policies due to dependents reform over the 12 months from 1 april 2023</p>	<p>Estimate the number of policies included in “TOTAL NUMBER OF POLICIES COVERED BY THIS PRODUCT as at 30 September 2022” that will migrate as a result of the dependents reform</p> <p>This number should reflect a movement for either part or all of the forecast contribution income 12 month period, therefore this may be a non-integer. For example:</p> <ul style="list-style-type: none"> • One person migrating for 12 months: -1 • One person migrating for six months: -0.5 <p>Enter zero where there are no movements.</p> <p>If impacts were reported last year, do not double-count in this year’s application.</p>	<p>-100 0</p>
<p>Estimated 2023 monthly premium (\$) adjustment due to</p>	<p>This is an automated field that estimates the 2023 monthly premium adjustment due to dependents reform migration.</p>	



Field	Data Entry Guidelines	Example
dependents reform migration		



Template B (Financials)

- Information requested in dollars should be entered as thousands of dollars (\$'000).
- Forecasts are required for the period October 2022 to March 2025.
- Figures under the Balance sheet and Capital Adequacy Standard for September 2022 should align with the September 2022 HRF602 returns.
- Hospital SEUs at September 2022 should reconcile with the HRF601 and HRF602.
- Expected dividend payments should be entered as a positive value and capital injections expected to be received as a negative value under 'dividend payments'.
- Capital Target Range should be expressed as total assets. This is the amount of assets required to be consistent with the targets outlined in the Capital Management Plan. Capital target range upper and lower bounds should both be entered. Where only a single target exists, this is to be repeated.
- **Change in DCL due to deferred treatments occurring – dollar amount** (row 44) – This is the central estimate of costs of services performed within the month arising from procedure deferrals¹. A negative amount reflects a reduction in the DCL
- **Change in DCL due to associated risk margin – dollar amount** (row 45) – This will capture the change in DCL due to changes in risk margins. A negative amount reflects a reduction in the DCL.
- **Other changes in DCL – dollar amount** (row 46 – formula driven) – This reflects other changes to the DCL not explained by rows 44 and 45. This would include any additional procedures deferred. A negative amount reflects a reduction in the DCL. A positive amount reflects an increase in the DCL. Non-zero amounts should be explained in the written report.
- **Deferred Claims Liability** (row 60). To be calculated as per APRA's [DCL FAQ](#). Method for calculating **Other liabilities amount (including deferred claims liability)** (row 81) is unchanged, and per APRA returns.
- **Deferred claims liability (valued at 98th percentile)** (row 82) - This item has been added to express the DCL included within the above item.
- Note: risk equalisation should be included in rows 44 and 45. The inclusion of claims handling in the DCL is at the discretion of the insurer. If claims handling is in the DCL then claims handling should also be in rows 44 and 45.
- **New Capital Standards:** insurers may choose to include projections of the fund's PCA and Capital Base under the new Prudential Standards over the forecast period. This is

¹ Restrictions on medical services introduced in March 2020 in response to COVID-19 have affected the pattern of claims by private health insurance policyholders. As some treatments were unable to proceed, insurers will typically have experienced a fall in benefit expenditure in the June quarter. However, in many instances policyholders affected by the restrictions will defer rather than forgo treatment, resulting in a delay in when they claim benefits from their health insurance policy. These claims that are deemed to have been deferred are referred to as the "deferred claims". Refer to APRA's ["Application of the capital framework for COVID-19 related disruptions" letter](#) dated 22 June 2020 for a discussion on the DCL and deferred claims.



optional as there is limited time between the final standards being published and submitting premium applications. This data is on a best endeavours basis and insurers may use simplifications. A brief description of the simplifications used should be outlined in Question 5 'Consistency with Capital Management Plan' of the written report.



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 contribution income. Savings should be stated as a negative amount as a percentage of Total Contribution Income. 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, rate protection and the dependents reform adjustment.

Template D (Other)

Hospital Product Margins

Insurers are asked to provide actual and forecast margins by product tier for the years commencing 1 April 2021 (actual), 1 April 2022, 1 April 2023 and 1 April 2024, based on past and proposed price increases. Risk equalisation should include gross deficit and calculated deficit. All relevant allocations should be done on a best endeavours basis.

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 2023 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.

Dependents reform

“Net overall impact of implementing dependents reforms \$'000” – insurers are asked to report the expected Gross Margin (\$) impact of implementing the dependents reforms. This should reflect all impacts including price changes. Insurers may also provide a description.

Grey cells have been linked to Templates A and C. The information in the grey cells for Apr23 will be used to adjust the forecast contribution income calculated in Template C. Insurers are asked to estimate net overall impact and the migration of policies for Apr24.

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:

- No additional columns or rows are inserted into [Template B](#).
- The excel spreadsheet does not contain links to other files.
- The capital target range is expressed as total assets, not net assets (capital).
- 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 that cells with a number have not been formatted to 'text'.
- Cells in [Template B](#) without a value have a '0' inserted and are not left blank.
- If an insurer has a single capital target rather than a range, this figure is entered into both the lower and upper bound.
- The formula cells have not been edited by the insurer.
- Data entered by the insurer should be values and not include calculations.
- Expected dividend payments should be entered as a positive value and capital injections expected to be received as a negative value under 'dividend payments'.
- 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 ID's are provided along with the new premium price requested for each product.