AMA

PRIVATE HEALTH INSURANCE REPORT CARD 2022

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INTRODUCTION

Our public hospital system is in crisis – the papers tell us the stories daily, stories of ambulance ramping, patients being treated in corridors because the beds are full, health practitioners overworked and exhausted and surgery waiting lists that seem to just keep growing longer. However, as bad as this picture is without our private health system it would be far worse. Our private hospital system covers 40 per cent of Australia's hospitalisations and performs 2 out of 3 elective surgeries. Our public system is dependent on effective delivery of private health services keeping the pressure off our public hospitals, and they have never needed this more than they do today.

Before the COVID 19 pandemic we saw the proportion of people with insurance for hospital treatment plummeting (with five years of continuous decline falling from 47.4 per cent in June 2015 to 43.6 per cent in June 2020). Many insurers had little or no profit margins left and the Australian Prudential Regulation Authority (APRA) was suggesting that we were about to see the start of a wave of amalgamations – maybe leaving us with only a handful of insurers.

We have now had 8 quarters (or two years) of continuous growth in the proportion of people with hospital treatment insurance (rising from 43.6 per cent in June 2020 to 45.2 per cent in June 2022) and along with this insurer profitability (on the back of reduced demand) has never been higher. At the start of the pandemic insurers promised not to make profits on the back of COVID 19. The AMA acknowledges that many insurers have returned funds back to their members, but their expenditure on management expenses and profit margins still remain generously high and we call for the money that patients pay in private health insurance premiums to come back to them in the form of healthcare delivery, not increased profits for insurers — there should be a mandated minimum amount that every insurer is required to return to patient care. But it currently doesn't happen that way, so the AMA believes that this is an area that clearly needs to be reformed.

With the increased cost of living pressures, Australians should be certain that they are receiving value for money from their private health insurance. A key component of this is choice when it comes to their healthcare, choice of hospital, of medical practitioner and of their treatment plan. The purpose of this document is to encourage insurers to put their members first when spending premiums, and to scrutinise behaviour that limits choice and undermines clinical autonomy of your doctors. The AMA appreciates the limited scope insurers have to increase revenue, which is why we have called for significant reform to the sector.

This is the seventh report card on private health insurance in the AMA's annual series. It is designed to assist patients/consumers by highlighting the differences in private health insurance policies and the operations of funds.

The report card provides consumers with indicators to help choose the right cover, noting that the most important features of a health insurance product will differ for each individual or family.[1]

This year's report card provides the latest comparison of the proportion of hospital and medical costs covered by each fund, and examples of common procedures where insurers pay different levels of benefits. These differences can have a significant impact on the support a patient might experience from their health fund when they undergo treatment. The AMA believes that highlighting these features can help consumers understand their likelihood of facing out-of-pocket costs across different insurance providers and products.

This report card compiles information from a range of sources and is not tailored for individual circumstances. As with any insurance policy, consumers should consider carefully which product is right for them and seek professional advice where necessary. This report card is not intended as a substitute for professional advice.

We hope the report card encourages people to review their private health insurance policy to ensure it meets their needs.

Prof Steve Robson
President
December 2022

1 The information in the figures in this report is current as at 15 October 2022 and is based on a detailed review of the policies offered by private health insurers, benefit schedules published by private health insurers, and information reported annually by the Private Health Insurance Ombudsman at www.phio.gov.au and the Australian Prudential Regulation Authority at www.apra.gov.au. These reports are updated throughout the year and the date of the publication is noted in the citation.

PRIVATE HEALTH INSURANCE IN AUSTRALIA

How health care is funded

Working out the right private health insurance for individuals and families can be a difficult task. The Commonwealth Government implemented key reforms to the system, which began to take effect on 1 April 2019 but were finalised on 1 April 2020. While these reforms make it easier to understand an insurance product, the private health insurance system in Australia is still complex and hard to navigate.

There are three key funders of private health care in Australia:

1. The Commonwealth Government, through the Medicare Benefits Schedule (MBS);
2. Private health insurers; and
3. The patient (through out-of-pocket costs).

Commonwealth, state, and territory governments fund public hospitals, which provide free admitted services to public patients.

To avoid surprises when it comes to settling medical bills, it is useful to understand which parts of medical fees are covered by each of the three key funders.

If patients are treated by a doctor outside of hospital as a non-admitted patient, whether by a general practitioner or another specialist, health insurance policies cannot be used to cover these costs.

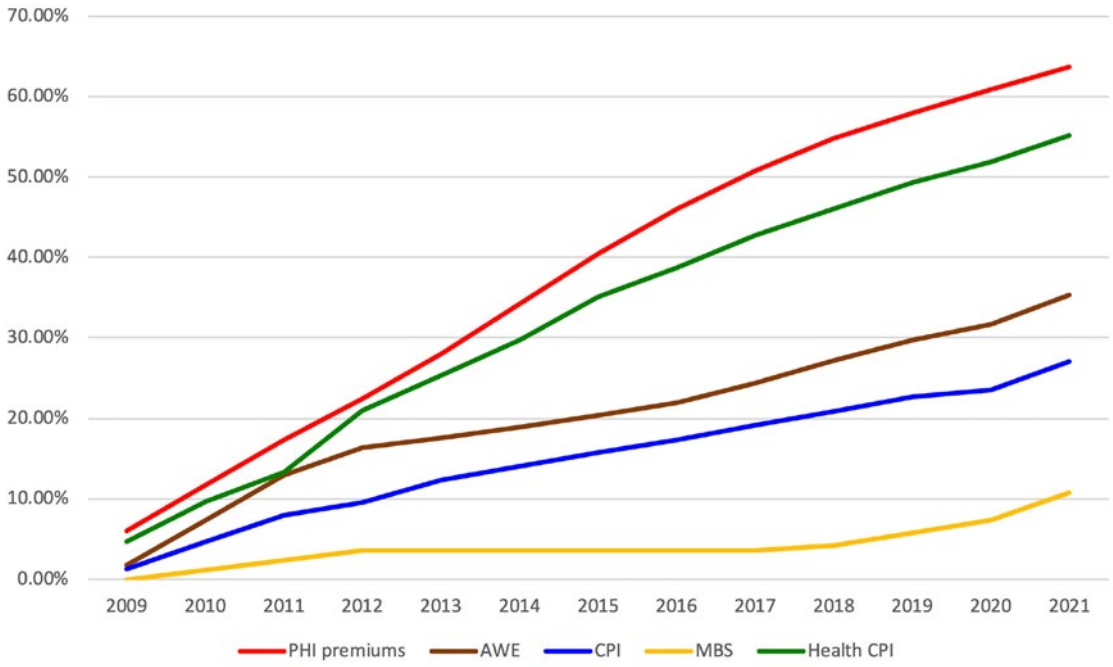
There are three aspects of private health insurance for hospital treatment that are most commonly misunderstood:

1. Not all private health insurance policies cover every medical treatment;
2. Insurers can change what is covered by a purchased policy, but they must tell you; and
3. Patients will sometimes have out-of-pocket costs even when their policy covers the medical treatment they need.

Premiums

A ‘premium’ is the amount consumers pay for their insurance coverage. Premiums are an income source for insurers, which helps pay for their business costs including (benefit) payments for hospital admissions. Once a premium is received from a consumer, the insurer is liable for providing coverage for claims according to the terms and conditions of their insurance policy. Each year, private health insurance premiums are adjusted to meet the increasing costs of providing health care, which are usually higher than other costs. The Commonwealth Government must approve the rate before it comes into effect.

Figure 1 – Increasing health costs; private health insurance premiums, health consumer price index and medical benefit schedule increase versus average weekly earnings and general consumer price index.[2]



Cover

Doctors working in the private health system sometimes see patients who think they are covered for treatment under their private health insurance policies, only to find out they are not.

This is understandable — people often assume, based on the significant premiums they pay, that they must be covered for everything. However, the term 'cover' does not always mean fully insured for all costs associated with a particular treatment or medical service.

For services delivered to privately insured patients admitted to hospital, private health insurance covers some, or all, of the cost difference between a doctor's fee and 75 per cent of the MBS fee (rebate) paid by the Commonwealth Government.

When a patient is treated as a private patient, either in a public or private hospital, each of the doctors involved with their care can charge a fee for their services. In addition, the hospital will also charge a fee for the hospital accommodation and any other services they provide.

2 Private health insurance (PHI) increase – increase in premiums:
https://www.health.gov.au/resources/publications/average-annual-price-changes-in-private-health-insurance-premiums
AWE – Average Weekly Earnings: 6302.0 - Average Weekly Earnings, Australia 2009-2020
MBS – Medical Benefit Schedule: https://feeslist.ama.com.au/resources-ama-gaps-poster
CPI – Consumer Price Index and Health CPI – Health Consumer Price Index: ABS data 2009 - 2020 6401.0 - Consumer Price Index, Australia

Excesses and co-payments for hospital admissions

Most health funds will offer the option of nominating an 'excess' or 'co-payment' on your hospital policy in return for reduced premiums. If you nominate a high excess or co-payment, then you may have a lower premium than someone with no excess.

The excess is an amount a patient will pay for hospital-related costs and is separate from any gap payment made for the doctor's treatment or services. Most policies now include excesses or co-payments.

An excess is a lump sum you pay towards your hospital admission before the health fund will pay its benefits.

Private health insurer contracts

As the financial position for health insurers becomes tighter, they continue to look for ways to reduce their costs. Some insurers are looking at ways they can improve the health of their customers (by promoting preventive health strategies), thereby potentially reducing the need for hospital treatments. Other insurers are looking at providing health care more flexibly by offering some services through 'hospital in the home'. These programs allow patients to remain at home during all, or some part, of their treatment.

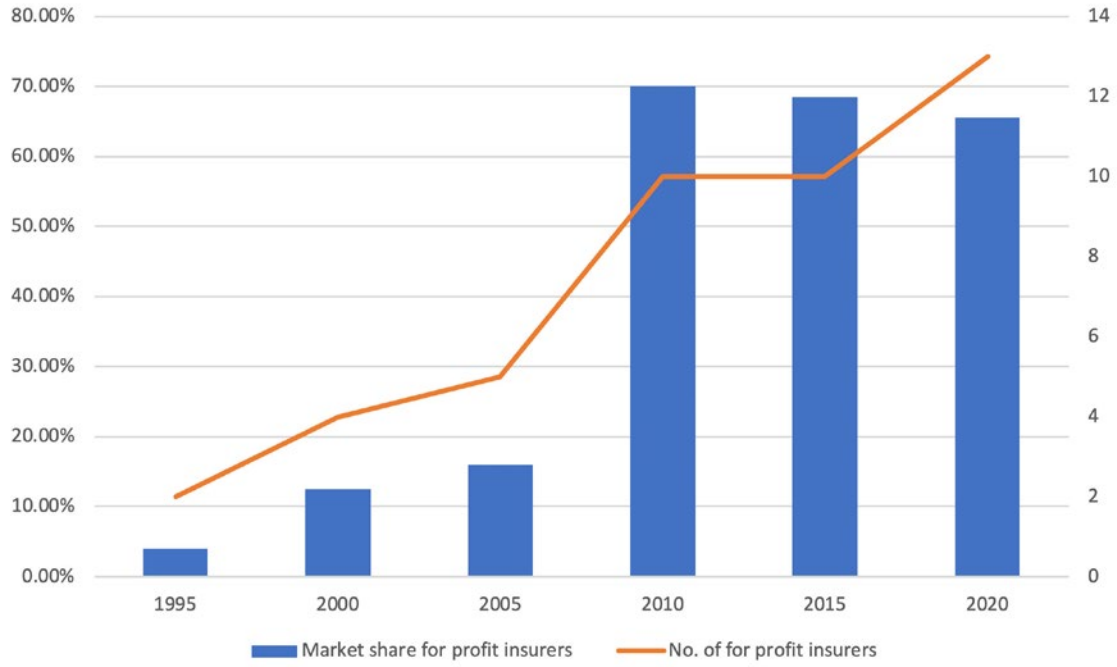
There has also been a marked change in the last decade regarding the composition of private health insurance companies. In 1995, only 4 per cent of the 49 insurers operated on a for-profit basis. Private health insurers have moved from primarily not-for-profit organisations, to the current situation where over 65 per cent of the insured population are now covered by for-profit funds (although there has been a small drift away from the larger for profits funds in recent times).[3,4]

With this increased number of for-profit insurers, and with the top for-profit insurers having a significant market share each, these big insurers are making increased use of selective contracting. Use of contracting arrangements enables insurers to influence, even dictate, the health care pathways available to their customers who are trying to reduce their out-of-pocket gaps.

This shift to larger for-profit insurers has been accompanied by a move from funds acting as passive payers to 'active funders' — in some cases as reported in the media, producing sizable profits from the sector for shareholders and large executive remuneration.

3 https://www.monash.edu/__data/assets/pdf_file/0005/2325884/Private-health-insurance-in-Australia.pdf Table 3
4 https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

Figure 2 – Changes in market share of for-profit health insurance funds – 1995 to 2020.[5, 6]



5 https://www.monash.edu/__data/assets/pdf_file/0005/2325884/Private-health-insurance-in-Australia.pdf Table 3
6 https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

PAYING FOR MEDICAL CARE

Out-of-pocket costs

Consumers are very concerned that they may face out-of-pocket costs for doctors' fees for their treatment — even when they have the top level of private health insurance coverage.

Doctors who treat patients will send them a bill for their services (a fee). Doctors, like other highly trained professionals, are free to set their fees at a level they believe is fair and reasonable. These fees take into account the cost of running a practice, including professional indemnity and other insurance, wages, rent, consumables, and other equipment costs.

If you are a patient admitted to hospital (public or private), and choose to be treated as a private patient, Medicare will pay for 75 per cent of the MBS fee for each service provided by a hospital doctor.

The out-of-pocket cost is the difference between the fees charged by the doctor and the combined MBS benefit and private health insurance benefit.

By law, private health insurers must top up the Medicare payment by at least 25 per cent of the relevant MBS fee. Insurers can pay a higher level of benefit than this in particular circumstances. These circumstances are explained under the heading 'no gap and known gap' on page 9.

Inadequate Medicare rebates and private health insurance rebate rises

The MBS is a list of the medical services (known as MBS items) for which the Commonwealth Government will pay a Medicare rebate, to provide patients with financial assistance towards the costs of their medical services.

Generally, Medicare pays a percentage of the MBS fee depending on the service provided:

- 100 per cent for consultations provided by a general practitioner (GP)
- 85 per cent for all other services provided by a medical practitioner in the community
- 75 per cent for all services that are provided by a medical practitioner during an episode of hospital treatment when the patient is admitted as a private patient.

The MBS was not designed to cover the full cost of medical services. MBS items have not been appropriately indexed (increased to meet health costs facing doctors) for many years.

Any 'gap' between the MBS rebate and the doctor's fee and any hospital fees ends up being paid by someone. This can be private health insurers, other funders or the patient. When the patient pays this gap, it is known as an out-of-pocket cost, as the patient is required to make up the difference out of their own pocket.

Under an indexing process, the MBS rebates are raised according to the Commonwealth Government's Wage Cost Index, a combination of indices relating to wage levels and the Consumer Price Index (CPI). This indexation has been considerably less than CPI rates, let alone health price increases.[7]

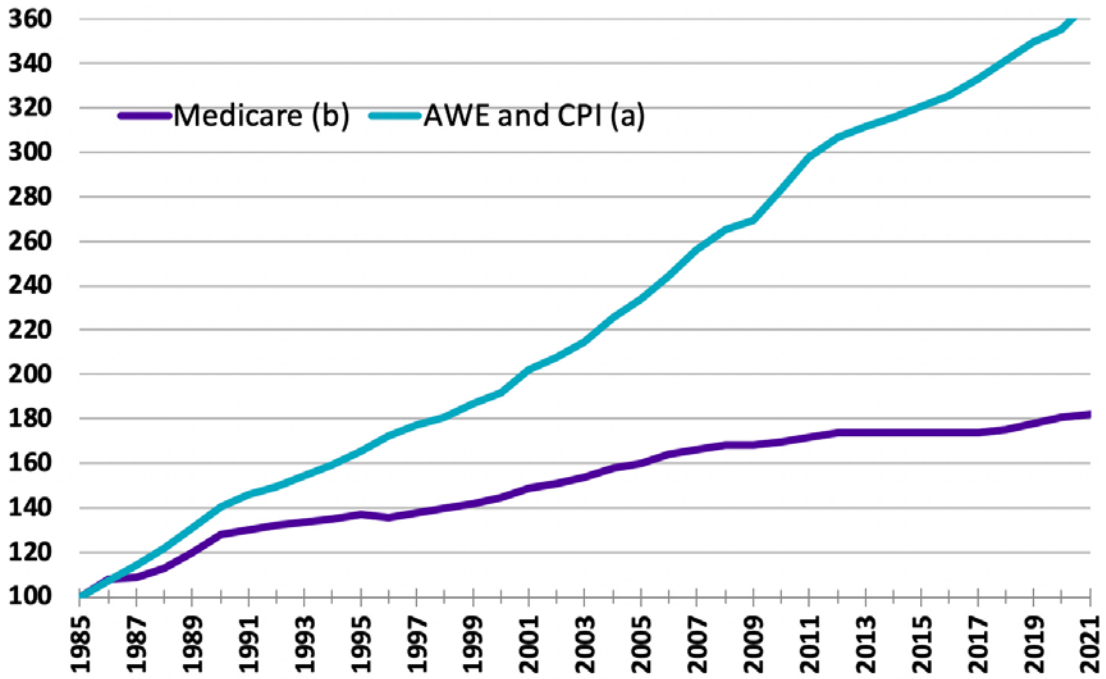
7 In the five years from 2016-2020, CPI rose 7.8 per cent, CPI for health alone rose 16.8 per cent but the MBS index only rose 3.7 per cent. ABS statistics from : https://www.abs.gov.au/AUSSTATS/abs@.nsf/second+level+view?ReadForm&prodno=6401.0&viewtitle=Consumer%20Price%20Index,%20Australia~Jun%202017~Latest~26/07/2017&&tabname=Past%20Future%20Issues&prodno=6401.0&issue=Jun%202017&num=&view=&
MBS indexation from: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads

In 2013, the Commonwealth Government froze the rebate, meaning that MBS rebates remained stagnant for more than five years, despite inflation and the rising costs of delivering health care. The freeze was lifted (but not for all items) in 2019. Additionally, most private health insurers rebate schemes are linked in some way to the MBS. In fact, a number of insurers have a direct link to the MBS rate — meaning that their rebates were frozen for the same period.

Medical fees need to cover income, staff wages, medical indemnity insurance, practice costs (including rent, medical supplies and equipment). All these costs have risen year on year, even if rebates haven't. This has contributed to a growing gap between the MBS rebate and the actual costs of providing health care in Australia, a gap that is being exacerbated by the rising inflation rate as shown in Figure 3.

Figure 3: Why is there a gap?[8]

(a) Index comprising of Average Weekly Earnings and Consumer Price Index (70:30).
(b) Index of MBS rebates as determined by the Commonwealth Government.



8 https://feeslist.ama.com.au/resources-ama-gaps-poster

No gap and known gap arrangements

Consumers should check whether or not a health insurer pays more than the minimum 25 per cent of the MBS fee required by law. It should be clearly and explicitly explained in every policy holder's health insurance policy brochure.

No gap arrangement

Most private health insurers offer 'no gap' arrangements, which is when the doctor agrees with the insurer to charge the exact same amount that the insurer has agreed to pay for that medical service. In many cases, doctors provide the service at 'no gap'[9] and patients will not incur an out-of-pocket cost for this medical service. The agreed no gap fee is generally higher than the MBS rebate.

Known gap arrangement

Many insurers will pay a benefit that includes a 'known gap'. This is where the insurer will still pay a higher benefit (than the minimum required by law) towards the doctor's fee if:

- the doctor has an agreement with the insurer
- the doctor's fee does not result in a patient out-of-pocket cost that is greater than the 'known gap' amount (which is usually $500).

The patient pays an out-of-pocket amount up to the 'known gap' rate for the medical service.

No arrangement

When there is no arrangement between a doctor and an insurer, or the doctor charges more than the known gap, the difference between the MBS rebate and the doctor's fee is made up by the patient's out-of-pocket costs, which can increase significantly in these instances. This is because the insurer in this situation will only pay the minimum benefit amount required — 25 per cent of the MBS fee.

Lower benefits paid by the insurer usually mean higher out-of-pocket costs. This can be confusing for patients, especially if not communicated early. It also means any increase in the doctor's fee above the no gap or known gap rates (depending on the insurer), no matter how small, results in a significant drop in payment from the insurer, and a far greater increase in the patient's out-of-pocket cost, as demonstrated in Figure 4 below.

Using a knee replacement (MBS item 49518) as an example, Figure 4 demonstrates the three billing and payment scenarios, where the private health insurer has set a medical benefit of $2216.85 and a 'known gap' amount of $500.00.

9 https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf

Figure 4: Private health insurer billing scenarios and out-of-pocket costs for a knee replacement.

MBS 49518 Fee: $1393.20 Benefit: 75 per cent = $1,044.90

	Doctor's fee	MBS Benefit	Insurance medical benefit	Out-of-pocket costs
Doctor accepts insurers medical benefit amount	$2216.85	$1,044.90	$1,171.95	$0.00
Doctor accepts insurers known gap arrangement	$2,716.85	$1,044.90	$1,171.95	$500.00
The benefit amount does not cover the doctor's fees	$2,750.00	$1,044.90	$348.30	$1,356.8

Agreement hospitals

The insurance benefits paid for hospital and even medical services depend not only on the type of cover you purchase, or the fees charged by your treating doctors, but whether your insurer has an agreement in place with the hospital in which you are treated.

If your insurer has entered into a contract with your choice of private hospital, you will have either no out-of-pocket hospital expenses or you will be provided with details of your costs. All major health funds have agreements with a significant number of private hospitals, but it is recommended that you check before deciding which hospital to be treated in.

This is important especially if you have a particular hospital in mind prior to treatment, or if you live in a rural area where the nearest agreement private hospital may be a distance away, or you want to ensure you can choose your doctor and, that your doctor can access your insurers' gap arrangements at that hospital.

Public hospitals don't have agreements with specific insurers, but most insurers treat them as though they are agreement hospitals.

As with your medical treatment, you are entitled to and should always ask your hospital or health insurer for an estimate in advance of the costs of your treatment, in both private and public hospitals.

To find out which private hospitals near you have agreements with your health insurance fund, you can contact your insurer or use the tool provided at: https://privatehealth.gov.au/dynamic/agreementhospitals/fund/aca

Informed Financial Consent

Navigating the health system is difficult for most people, but even harder when you are sick or disadvantaged.

Medical practitioners know how important it is to ensure their patients understand their treatment options, and the need to support them in understanding the fees and costs associated with that care.

The AMA has worked with a range of key medical organisations to create a comprehensive resource that supports a collaboration between doctors and their patients.

This resource supports patients to be more engaged in conversations with their doctors, with their health fund and with their choice of hospital. It assists in creating a dialogue that will improve transparency about treatment options, charges and expected out-of-pocket costs.

The guide is designed to empower patients with important information to help them understand medical costs and give them confidence to discuss and question fees with their doctors.

The Informed Financial Consent guide includes:

- an Informed Financial Consent Form for doctors and patients to use together
- information on fees and medical gaps
- questions for patients to ask their doctors about costs.[10]

Publishing doctors' fees

Throughout the last few years, the publication of doctors' fees has been an area of ongoing media and public scrutiny. On 30 December 2019, the Minister for Health launched the Medical Costs Finder[11] to help Australians understand the cost of common medical procedures provided by specialist medical professionals.[12]

This tool can be used to:

- see how much people have paid out-of-pocket for a medical service
- compare the costs estimated by your specialists and other health providers for a service with the typical costs for the same service.

Currently, the website shows general information on typical costs for common services both in and out of hospital, with over 1,000 specialist treatments currently listed. The Federal Department of Health and Aged Care is working to enhance the website so specialists will be able to add their individual fees for common medical procedures and their arrangements with different private health insurers.

While this helps you better understand what is typically paid, it does not provide you with specific information about your procedure which will vary depending on your age, risk factors and any complicating issues. Over the last 12 months, the Australian Government has been working on adding new functionality to this website which will allow individual medical specialists to publish their indicative estimate fees and private health insurer gap arrangements for a selected number of high-volume services they provide.

The AMA would like to highlight that this cost is not a quote, but is an indicative fee aimed at providing consumers with a better understanding of what contributes to out of-pocket costs and the value the right private health insurance cover for their needs can provide.

10 Links to the AMA resources on Informed Financial Consent can be found on page 26
11 https://www.health.gov.au/resources/apps-and-tools/medical-costs-finder#what-the-medical-costs-finder-is
12 https://www.greghunt.com.au/new-website-to-improve-consumer-understanding-of-medical-costs/

The website does not include any information on how long you are likely to wait for elective surgery in your local public hospital which is important information when considering your options. The AMA has a tool which will help you visualise how long you will have to wait on average at your local hospital: www.ama.com.au/clear-the-hospital-logjam.

The AMA is strongly committed to information sharing between a doctor and a patient to create an agreed treatment plan and understand its associated costs. But a more accurate way to fully understand your likely out-of-pocket costs is not just a website, but quality, informed financial consent undertaken with your medical practitioner.

To that end, the AMA publishes extensive information on informed financial consent, billing practices, guides, and suggested questions for patients to ask their doctor, so they fully understand their individual situation.

A patient's out-of-pocket costs are determined by numerous factors, including:

- which MBS item number is used for their particular procedure
- whether they are actually covered under their policy for that procedure
- whether the patient has served their waiting periods
- whether the doctor has an agreement with the health fund
- what other doctors and tests are involved
- whether the hospital has an agreement with the health fund
- the benefit rate set by the fund
- the State the patient lives in.

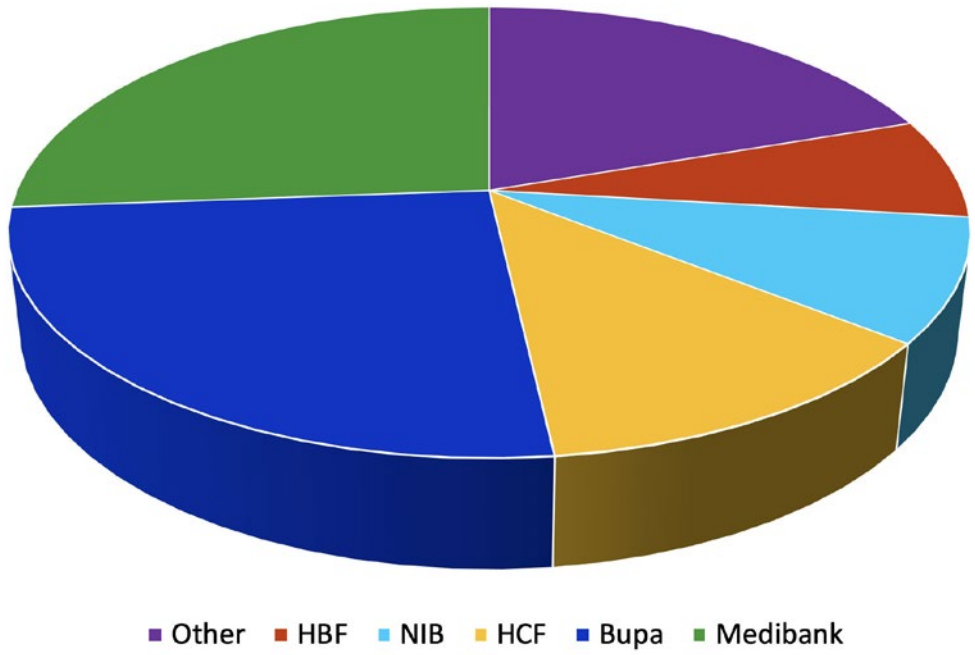
A patient's out-of-pocket cost comes from the doctor's fee and by the benefit paid by a fund. These rates are not uniform across insurers, procedures, states, and hospital setting.

To ensure their patients can access the wide number of no gap or known gap schemes from the full range of insurers (and reduce their out-of-pocket costs), medical practitioners must have multiple fee schedules (sometimes up to 17 different rates) for the same procedure, simply to comply with the different rebates paid by health funds to meet their no gap or known gap requirements for that one procedure.

A general practitioner who has an ongoing relationship with their patient is best placed to refer for appropriate specialist care. A doctor should be prepared to outline their estimated costs when contacted by patients, particularly for standard treatments or initial consultations.

WHAT YOUR PREMIUMS GIVE BACK

Figure 5: Insurer market share.



The five largest health insurers have a combined market share of over 80 per cent and contributed to almost 78 per cent of total health fund benefits paid in 2020–21.[13] This market share also gives the large insurers significant power to negotiate contracts with private hospitals and medical practitioners.

Benefits paid by health insurers

Each insurer has its own schedule of benefits it pays for admitted medical services (those carried out in day or night stay hospital).

For admitted hospital treatments, the level of benefits paid by the insurer will depend on the insurer, the particular insurance policy, and the insurer's arrangements with the treating doctor, and the treating hospital.

Private health insurers will generally aim to set premium levels to cover the expected costs of benefits plus the insurer's management costs. However, the benefit that an insurer may agree to pay varies by insurer, policy and procedure.

When there is a difference between the doctor's fee and the insurance benefit, out-of-pocket costs can occur. It is a common misunderstanding that the doctor's fee is the reason for an outofpocket cost. There can be a large difference in the amount an insurer will pay towards a medical service, and it varies from fund to fund and procedure to procedure.

13 APRA, Statistics: https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

Figure 6 demonstrates the different benefit amounts paid by insurers for a select range of common procedures. Red indicates the lower level of benefits paid, and green shows which insurers pay a higher level of benefits. The scale is relative to the other benefits paid for the same procedure across the listed insurers.

It is important to note that the table does not represent the entire industry. These payments relate to the relevant item and insurer description, and as such there may be additional items used for any particular procedure or service (i.e. pathology, diagnostic imagery, anaesthetics) or for any other doctors involved.

Generally speaking, the greater the benefits, the less likelihood of out-of-pocket costs.

Figure 6: Benefits paid for select admitted medical services by different private health insurers as at 15 October 2022.

MBS Item	MBS Description	MBS Fee	Bupa	HCF no gap rate	AHM/ Medibank Private	NIB	AHSA	HBF no gap rate	Var Lowest to highest
326	Attendance by a consultant psychiatrist	$197.10	$225.60	$236.50	$238.50	$229.75	$222.70	$248.45	$25.75 12%
18216	Epidural anaesthesia during labour	$200.75	$325.35	$325.20	$316.05	$312.75	$314.20	$327.80	$15.05 5%
12203	Overnight Investigation for sleep apnoea	$621.60	$740.25	$739.70	$752.00	$753.75	$711.50	$781.25	$69.75 10%
13950	Cytotoxic Chemotherapy	$114.20	$136.30	$145.05	$134.75	$129.85	$125.50	$147.35	21.85 17%
16519	Uncomplicated Delivery (of baby)	$733.65	$2091.35	$2112.90	$1994.90	$1639.70	$1686.00	$2190.05	$550.35 34%
16522	Complicated Delivery (of baby)	$1722.50	$2474.95	$2463.20	$2446.10	$2430.95	$2230.70	$2742.30	$511.60 23%
30445	Cholecystectomy	$879.70	$1269.30	$1249.15	$1252.15	$1055.60	$1290.70	$1202.95	$235.10 22%
30720	Appendicectomy	$470.90	$683.00	$668.70	$682.80	$636.45	$669.50	$647.05	$46.45 7%
30648	Femoral or inguinal hernia or infantile hydrocele	$491.10	$707.50	$697.35	$707.20	$663.75	$964.70	$674.75	$300.95 45%
31512	Breast, malignant tumour, removal	$687.30	$1019.40	$975.95	$938.95	$928.95	$943.80	$930.75	$90.45 10%
32222	Colonoscopy	$353.45	$495.40	$484.25	$470.10	$457.35	$460.60	$475.55	$38.05 8%
32139	Haemorrhoid-ectomy	$388.75	$555.85	$532.60	$553.30	$503.00	$638.80	$526.45	135.8 27%
32500	Varicose Veins	$116.05	$179.30	$169.45	$181.45	$157.95	$172.40	$157.80	23.65 15%
35657	Vaginal Hysterectomy	$713.30	$1169.70	$1155.55	$1168.25	$1075.25	$1116.40	$1291.45	$216.20 20%
37623	Vasectomy	$243.05	$374.25	$369.45	$393.75	$371.20	$359.80	$333.95	$59.80 18%
38502	Coronary Artery Bypass	$2490.75	$3775.00	$3761.05	$3772.15	$3498.75	$4246.10	$4084.25	$747.35 21%
38316	Cardiac percutaneous coronary intervention	$1675.35	$2378.90	$2362.25	$2462.75	$2259.35	$2518.20	$2499.85	$258.85 11%
39331	Carpal Tunnel Release	$292.60	$502.80	$479.85	$490.20	$443.55	$460.90	$477.55	$59.25 13%
39710	Craniotomy	$2561.95	$4206.70	$4201.60	$4091.20	$3884.15	$4035.40	$4182.60	$322.55 8%

MBS Item	MBS Description	MBS Fee	Bupa	HCF no gap rate	AHM/ Medibank Private	NIB	AHSA	HBF no gap rate	Var Lowest to highest
41789	Tonsils or Tonsils and Adenoids	$312.60	$522.75	$575.20	$516.00	$468.85	$538.70	$542.35	$106.35 23%
42702	Cataract Surgery	$804.10	$1288.45	$1246.35	$1251.55	$1216.35	$1298.50	$1285.70	$82.15 7%
46340	Wrist Synovectomy	$418.95	$653.95	$649.35	$703.85	$631.50	$649.70	$621.00	$82.85 13%
49518	Knee Replacement	$1393.20	$2292.45	$2201.25	$2216.85	$2140.05	$2689.50	$2234.60	$549.45 26%

1	2	3	4	5	6	7	8

As Figure 6 shows, the different amounts paid by insurers for the same procedure can vary significantly. There is up to 45 per cent variation for MBS Item 30648, Femoral or inguinal hernia or infantile hydrocele, resulting in a difference of $300.90 between the top insurer and the one paying the least. For MBS Item 16519, Uncomplicated Delivery (of baby), the top rebate is 34 per cent or $ 550.35 more than the lowest. These differences contribute to the out-of-pocket expenses patients incur, they are also a good reason to look beyond just the price of the annual premium levels of an insurer to ensure that you get value for your insurance policy.

State-based comparison of gaps

In addition to varying the benefit paid, insurers can have a higher percentage of medical and hospital services covered at no gap compared with another insurer (in the same state or territory). This is a signal that the first insurer has a more effective rebate scheme in that state, and that policy holders are less likely to have an out-of-pocket cost after their medical service. Overall, the best private health insurer for consumers may depend on where they live.[14]

There are two different measures of insurance benefits:

- The percentage of hospital-related charges covered (this includes accommodation at the hospital, provision of nursing care, and the cost of any prostheses)
- The percentage of medical services provided at no gap. This is the percentage of the doctor's fees paid by that insurer that are provided with no gap.

The value of some insurers' gap schemes and benefits schedules can differ between states and these differences are not apparent in the national figures.

14 Doctors are free to decide whether to participate in a particular fund's gap cover arrangements. A number of factors can affect the acceptance of the scheme by doctors, including: whether a fund has a substantial share in the health insurance market of a particular State, the level of funds paid under the gap arrangements compared with the doctor's chosen fee, and the details of the insurer's gap cover arrangements, including any administrative arrangements.

TRENDS IN PRIVATE HEALTH INSURANCE

Impact of the COVID-19 Pandemic

Elective surgery restrictions

Following a decision by National Cabinet, in the context of ensuring the health system maintained adequate capacity to deal with the COVID-19 pandemic, restrictions were applied to selected elective surgeries from 26 March 2020.

Under these restrictions, only Category 1 and exceptional Category 2 procedures could be undertaken. These restrictions were eased (but not fully lifted) from 29 April 2020, allowing all Category 2 and some important Category 3 procedures to be performed. Since this period different jurisdictions have reduced or ceased elective surgery at different times dependent on the public health measures being taken to counteract the pandemic.

These restrictions and reductions have led to an overall decrease in admissions from elective surgery waiting lists and impacted waiting times for elective surgery in the last year.[15]

Accordingly, private hospitals have managed successive lockdowns which saw their elective surgery turned on and off, in some states multiple times. Additionally, private hospitals supported Australia's response to COVID by, providing elective surgery to public patients through successive lockdowns, taking public hospital and aged care patients when needed to take pressure off the public system, and providing their staff to help with a range of pandemic activities.

Australia's health system has been put under pressure by COVID like never before and this pressure has not abated. Both the public and private sectors will have long waiting lists, supply and workforce issues, all of which will extend for years ahead.

Private health insurers response

At the start of the pandemic private health insurers stated that they would not make a profit from the COVID-19 restrictions[16] and many have taken a range of steps to deliver on this promise as well as supporting people financially affected by the pandemic. These steps have included:

- delaying (but not cancelling) the insurance premium increase for 6 months or longer (in some cases 12 months)
- providing financial relief to affected customers (how this has been done has varied from insurer to insurer)[17]
- providing money directly back to members.

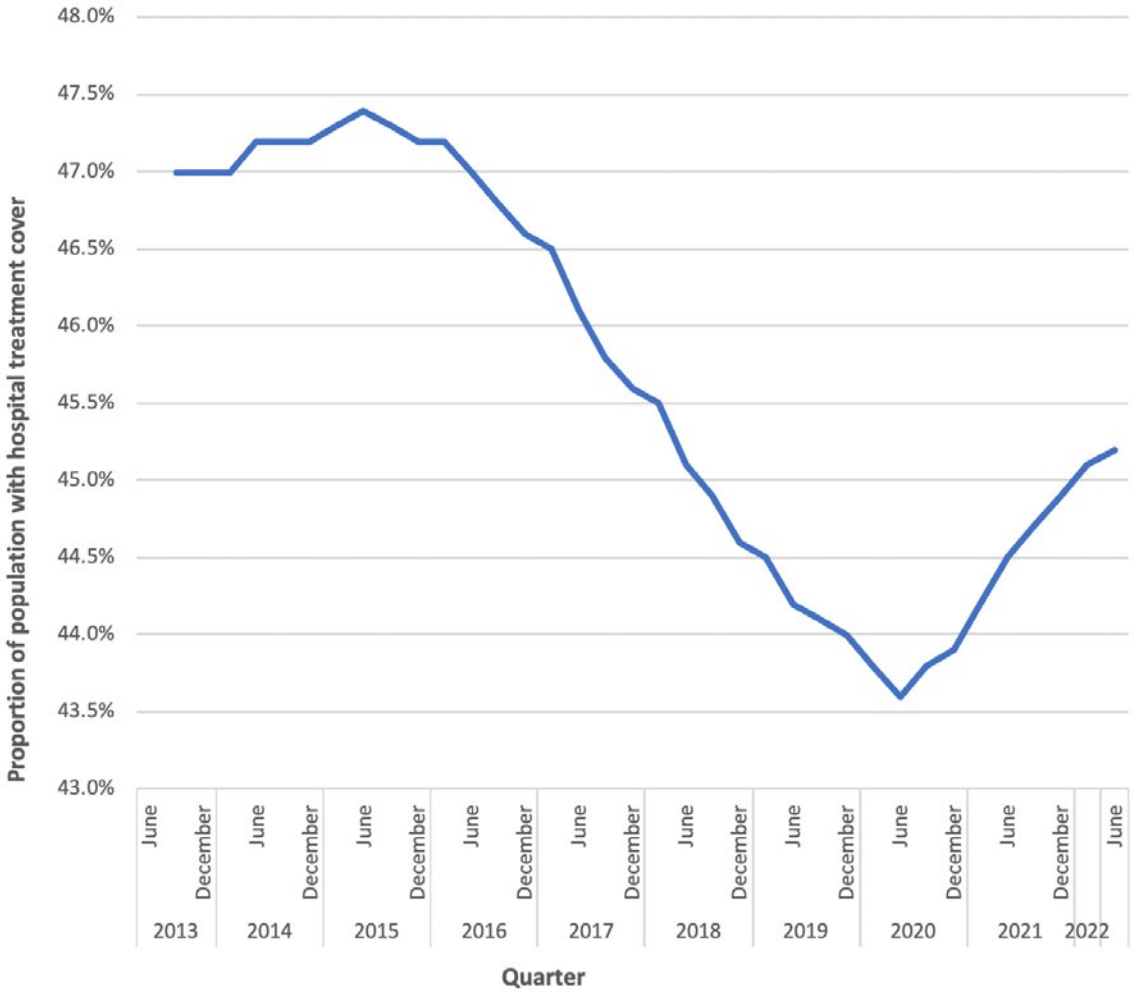
However, insurers' outlays have decreased due to the reduction in services provided and this has resulted in their increased profitability. This has led the ACCC to state that "We will continue to monitor the actions of insurers to return all profits made due to COVID19 to policy holders as they promised and report on it in our next annual report on the private health insurance industry".[18]

15 https://www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery
16
17 https://www.privatehealthcareaustralia.org.au/health-funds-committed-to-providing-financial-relief-for-members-impacted-by-covid-19/
18 https://www.accc.gov.au/media-release/health-funds-must-exercise-caution-when-calculating-covid-19-relief-for-policyholders

Private health insurance performance

In the 12 months following the release of our 2021 report card there were 235,699 more people with hospital treatment insurance, an increase of 0.7 per cent.

Figure 7: Private Health Insurance - proportion of population with hospital treatment cover.[19]

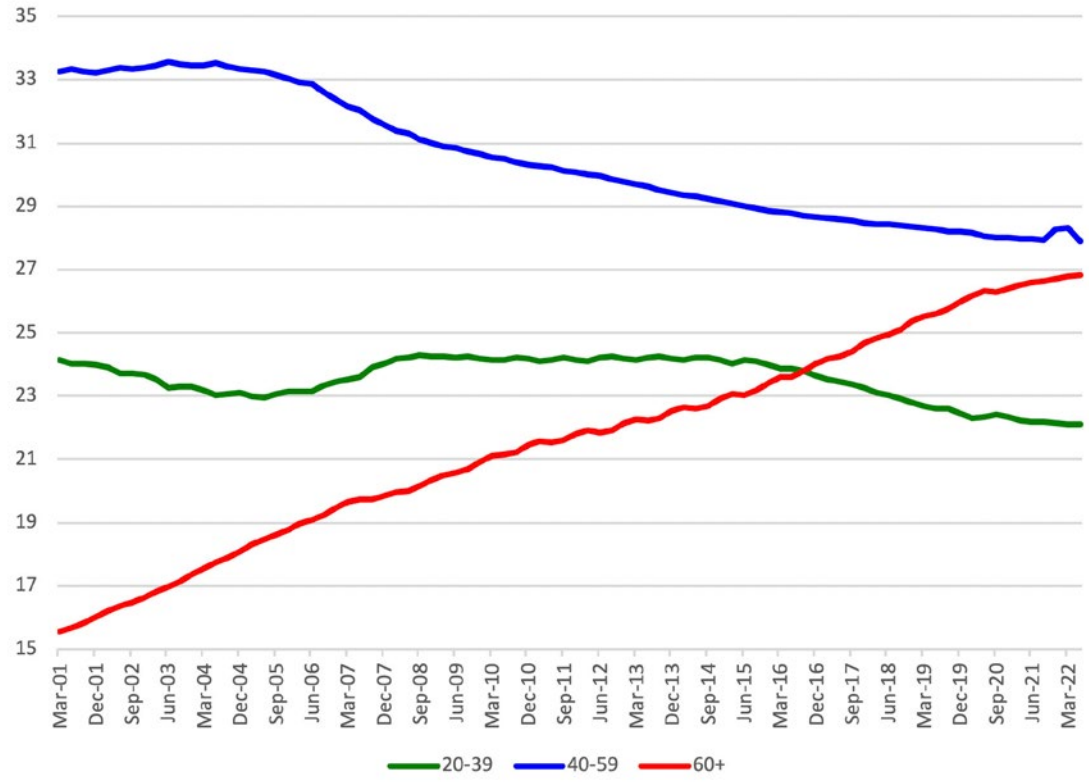


Although the above graph shows a steep drop in overall private hospital insurance between the second half of 2015 to 2020, not all age cohorts dropped private health insurance at the same rate. Between June 2019 to June 2020 the number of people aged over 65 with hospital treatment policies increased by 71,496 or 0.71 per cent. Analysis completed for the AMA indicates in the year to December 2018, Australians aged 55-64 received around 88 per cent of the overall insured person average benefits, while those aged 65-74 received around 160 per cent of the average. The figures at this point then increase dramatically — those aged 75-84 received 260 per cent, while those who have insurance and are 85 years or older received a staggering 310 per cent of the average benefits.[20]

Since June 2021 we have seen a rise in the number of people taking up private health insurance policies. But Figure 8 shows that the over 60 insured aged cohort overtook the 20-39 year-old cohort almost 4 years ago. Even with this increase in membership, the current trend will see the 60+ age group overtake the 40-59 year-olds in the foreseeable future to become the largest insured age cohort.

19 APRA Statistics Quarterly private health insurance statistics 2013-2022
20 APRA Statistics, Insurance, membership and benefits statistics, December 2018. "AUSTRALIA" worksheet, Page 2, "Hospital Treatment and General Treatment Combined"

Figure 8: Demographics of the insured population (age groups with hospital treatment insurance as a percentage of the insured population).[21]



Change in exclusions

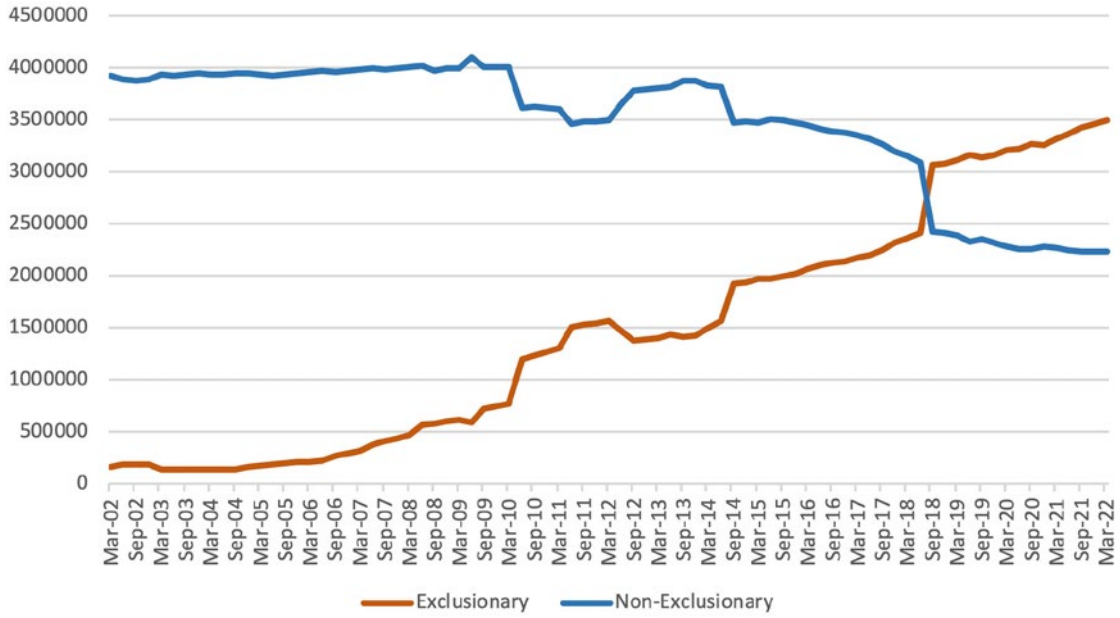
Another useful measure for consumers to understand the value of private health insurance is examining whether their policy contains exclusions.

As Figure 9 shows, virtually no policies had exclusions only 15 years ago. In 2018, for the first time, a majority of policies contain exclusions, and this trend has continued from this point.

An exclusion for a particular condition means a policy holder is not insured for treatment as a private patient in a private or public hospital for the particular conditions excluded. Over time, the number of policies containing exclusions has grown significantly. In 2018, the number of policies with exclusions overtook the number without. (Figure 14)

21 APRA Statistics Private Health Insurance Membership Trends 2001-2021

Figure 9: Change in private health insurance exclusionary and non-exclusionary policies (20012021).[22]



Private health insurer expenses

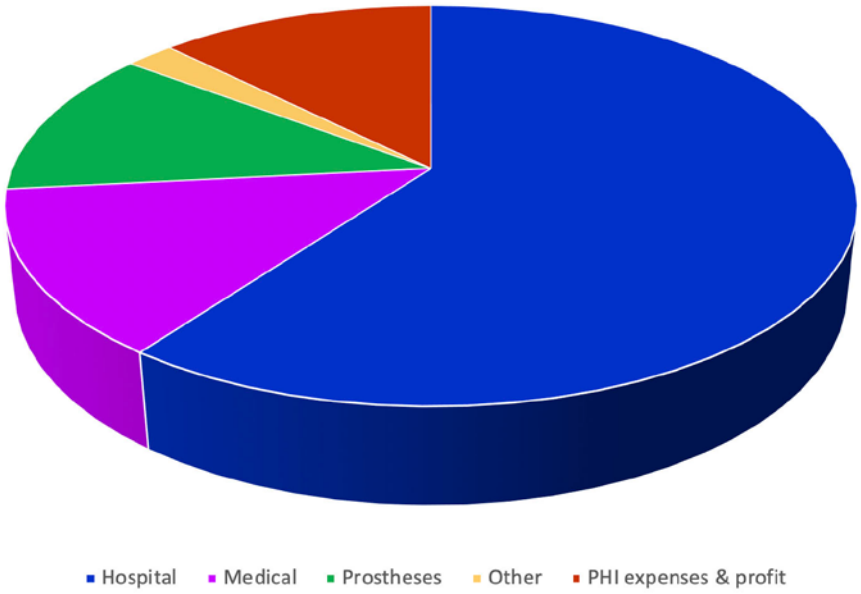
Private health insurers will generally aim to set premium levels to cover the expected costs of benefits (that is, payments made on behalf of insured members for admitted hospital costs including doctors' fees), plus the fund's management costs. Management expenses comprise the amount of premiums per policy that are used to manage the business of the fund. All funds have management expenses and depending on their position in the market and whether they are "for-profit", they can have varying marketing costs, staff salaries, overheads and profit margins that need to be built into these expenses.

Regardless of whether a private health insurer is for or not-for-profit they have a number of expenses in common. For any episode of healthcare funded by an insurer they cover the following main expenses:

- Hospital expenses — the amount paid to the private hospital
- Medical expenses — the amount paid to doctors
- Prostheses — the amount paid to buy item such as hip and knee joints or cardiac stents.

22 APRA Statistics - *Private Health Insurance Membership and Benefits - Part 1 Policies and Insured Persons 2001 – 2021*. Viewed on 28 July 2022.

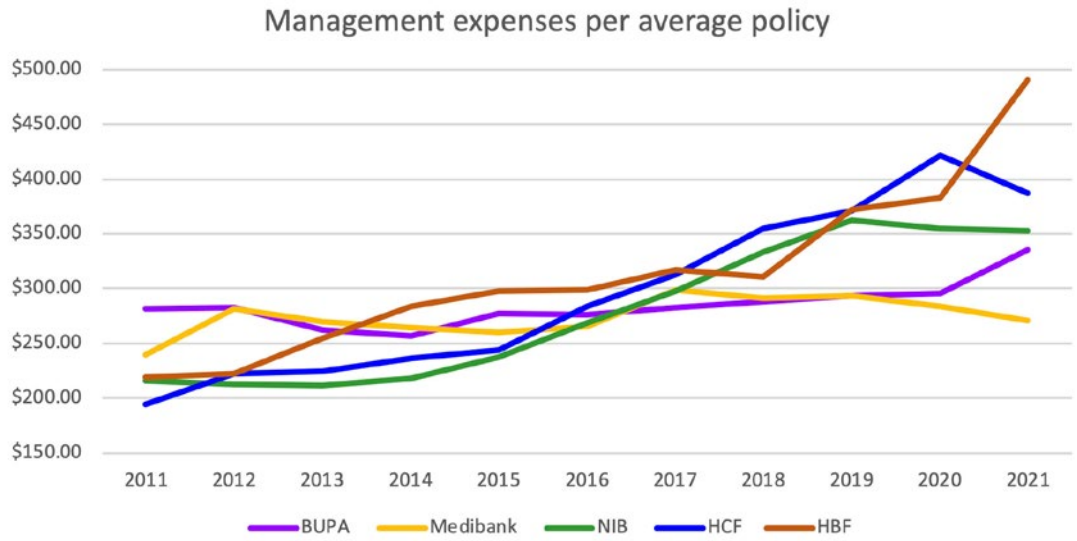
Figure 10: Health insurer distribution of premium revenue.



But all insurers also incur management expenses, the costs of them doing business such as wages, rent and claims handling expenses and for-profit insurers also have the profits they make. The amount paid by insurers for management expenses can vary considerably with some insurers paying over 15 per cent of their contribution income, but the industry average is 11.7 per cent.

As a result, if management expenses as a proportion of payments are higher, a smaller proportion of premiums is being spent on members' claims for admitted hospital treatments. Naturally, such calculations are complex, but it is likely that a greater proportion of premiums being paid towards benefits is one indicator of value and return on investment.

Figure 11: Change in management expenses per average policy for the largest five private health insurers (by marketshare).[23]



Change in complaints

The Private Health Insurance Ombudsman (PHIO), which is part of the Commonwealth Ombudsman's Office, provides private health insurance members with an independent service for health insurance complaints and enquiries.

As part of the reforms announced in 2018, PHIO received additional resources to investigate complaints and other issues, and the Commonwealth Government announced significant improvements to the information statements provided by insurers — the Private Health Insurance Statement (called a PHIS — see next section for details).

In spite of fluctuations in total numbers, the greatest level of problems that consumers experience continues to be across a small number of constant issues (see Figure 12). The highest number of complaints have centred on benefits (non-payment or delayed payment, gaps paid); premium increases; membership issues; waiting periods for pre-existing conditions; and service, including information provided that doesn't meet consumer needs.

Incorrect or unhelpful information can lead to people misunderstanding what they are covered for, and result in insured patients facing unexpected out-of-pocket costs. This can be particularly problematic when the advice from an insurer is provided verbally or in-person.

Moreover, online detail about a policy or in brochures can be challenging to understand for the majority of consumers.

23 Private Health Insurance Ombudsman State of the Health Funds Reports 2011-2021

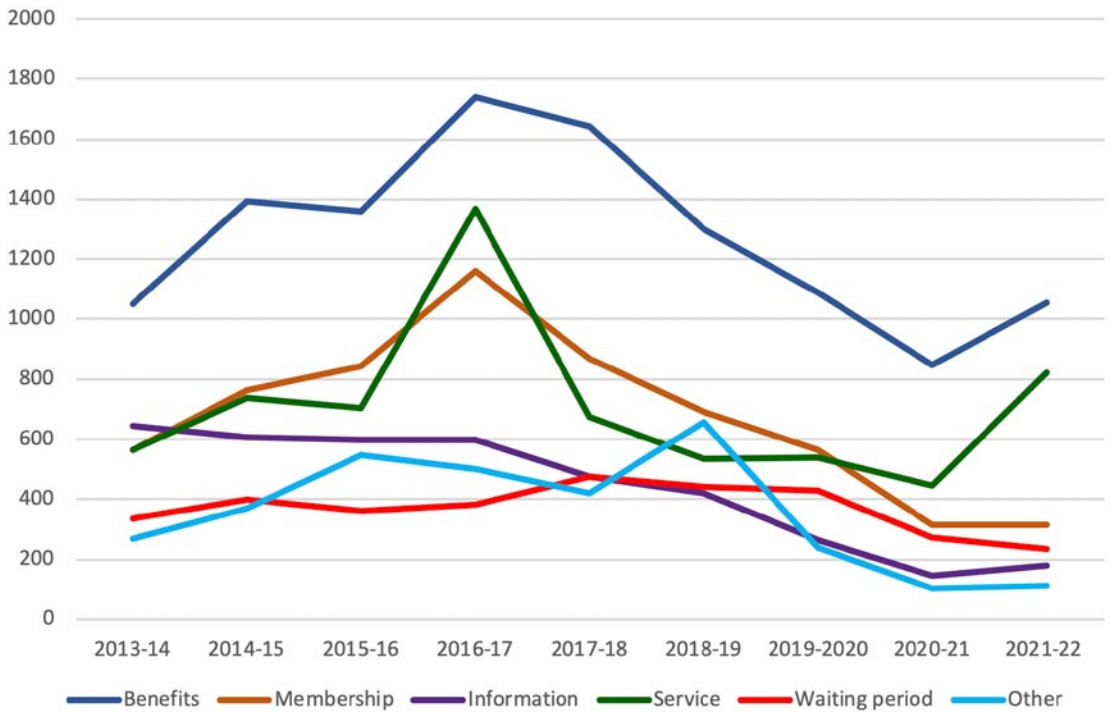
The AMA recommends that consumers with queries about their private health insurance speak to their insurer in the first instance. The AMA suggests you always ask health insurers to confirm their advice in writing. This way you can double check your understanding with the PHIO if you are unsure of your benefit eligibility or entitlements under your policy. If you have a planned admission, always obtain written confirmation of your benefit entitlements from your insurer well before you are admitted to hospital.

If a consumer requires further assistance or wants to lodge a complaint about a private health insurer, they can contact PHIO directly on 1300 362 072 or at phio.info@ombudsman.gov.au.

The PHIO protects the interests of people covered by private health insurance. It carries out this role in a number of ways, including through an independent complaint handling service. The PHIO provides information on complaints about insurers and how they are resolved, particularly through its annual report.

In 2018 the PHIO was given new powers to investigate complaints and other issues. It upgraded and enhanced its website www.privatehealth.gov.au and has released a simple comparison tool to help compare health insurance products.

Figure 12: PHIO complaints, by issue, 2013–14 to 2019–20[24,25]



24 Private Health Insurance Ombudsman State of the Health Funds Reports, Commonwealth Ombudsman Annual Report additional Private Health Insurance Information) 2014-2019, 2019-20 Private Health Insurance Ombudsman Quarterly Bulletins

25 The increase in complaints is partly attributable to complaints made about Peoplecare Overseas Health Cover resulting from unused policies due to COVID-19 border closures https://www.ombudsman.gov.au/__data/assets/pdf_file/0016/115243/PHIO-QU-Apr-Jun-2022-and-Annual-Summary-v2.pdf

Private Health Information Statement (PHIS)

A key aspect of the reforms has been an increase in transparency. Health insurers are now required to send members an annual statement summarising what their policy does and does not cover, and again each time their policy changes.

Policy information for Gold, Silver, Bronze, or Basic hospital and general treatment policies are required to be sent to members in the form of a PHIS. This includes information about what is and is not covered, based on the new tiers and clinical categories of treatment. From 1 April 2020, all policies have been required to be summarised in a PHIS document.

A PHIS provides a summary of the key product features. It allows you to see if your broad needs are covered and where products differ in both price and features. To get the full details for the insurance policy you should still contact the insurer.

People can search for and compare a PHIS from every available policy in Australia on the Government website www.privatehealth.gov.au.

MORE INFORMATION ABOUT PRIVATE HEALTH INSURERS AND THEIR PRODUCTS

AMA resources

The AMA has a number of public position statements and resources relevant to medical fees:

- Setting Medical Fees and Billing Practices (2017).
- Informed Financial Consent position statement (2015).
- Informed Financial Consent - a collaboration between doctors and patients. Assisting patients to understand their health care and its costs.

To read more about how the health care system funds Australians' medical care, visit www.ama.com.au/article/guide-patients-how-health-care-system-funds-medical-care.

Commonwealth Government information

The Commonwealth Government hosts a website that provides:

- more detailed information about how private health insurance works
- a tool for comparing the features of policies
- the Private Health Information Statements for every policy.

www.privatehealth.gov.au

Medical Cost Finder

The Commonwealth Government has developed an online tool which covers the costs of common services in and out of hospital that patients want to know more about. The tool's results are based on the most recent publicly available Government data about what people have paid for medical services.

www.health.gov.au/resources/apps-and-tools/medical-costs-finder#what-the-medical-costs-finder-is

Private Health Insurance Ombudsman – PHIO

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If a consumer requires further assistance, or wants to lodge a complaint about a private health insurer, they can contact PHIO directly on 1300 362 072 or through the website at www.ombudsman.gov.au/How-we-can-help/private-health-insurance.

MBS Online

The Medicare Benefits Schedule (MBS) Online contains a listing of the Medicare services subsidised by the Commonwealth Government. Search the MBS for all the latest fees and information at www.mbsonline.gov.au.

LIST OF FIGURES

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