

AMA Private Health Insurance Report Card

2023



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INTRODUCTION



Professor Steve Robson
Federal AMA President

Australia has made it through the worst of the COVID–19 pandemic, but in 2023 our public hospital system remains in crisis. As detailed in the Australian Medical Association’s [2023 Public Hospital Report Card](#), pressure from a growing and ageing population with complex, chronic health conditions continues to push public hospitals to the limit.

Many measures of public hospital performance continue to worsen, including lengthening waiting times in emergency departments, longer wait times for planned surgeries, and a continuing decline in the number of hospital beds available for people aged over 65. While the AMA continues to push for a new funding agreement to support public hospitals to expand their capacity, it remains true that without our private health system, the situation would be far worse for many patients.

Our private hospital system covers 40 per cent of Australia’s hospitalisations and performs two out of three elective surgeries. Our public system therefore depends on effective delivery of private health services to reduce some of the pressure there would otherwise be on public hospitals, and to ensure patients can access planned but non–emergency surgeries within appropriate timeframes.

The proportion of Australians with private hospital health insurance has increased substantially since the onset of the COVID–19 pandemic. While there has been a further decline in the number of private health insurers over the past year, with several smaller insurers being amalgamated into larger funds, the financial situation of the private health insurance sector remains very robust.

As discussed in this report, the expenditure of many insurers on management expenses has continued to increase over the past year, and the profits made by the largest for-profit insurers continue to be concerningly high. At the same time, Australian Prudential Regulation Authority (APRA) statistics show that the proportion of hospital insurance policy premiums returned to patients in the form of insurance benefits for hospital treatment has fallen from 88.02 per cent in 2018–19 to 81.6 per cent in 2022–23.

The AMA [continues to call](#) on the federal government to ensure that more of the money that patients pay in private health insurance premiums comes back to them in the form of healthcare delivery and rebates for hospital treatment rather than increased profits for insurers. We believe there should be a mandated minimum amount that every insurer is required to return to patient care and will continue to fight to improve the value for money that consumers receive from their private health insurance.

This report card seeks to encourage insurers to put their policy holders first, and to scrutinise insurer behaviour that limits patient choice and undermines doctors’ clinical autonomy in determining the treatment that will best meet your healthcare needs.

The other key purpose of the report card is to provide information to help consumers check whether they are receiving value for money from their private health insurance by highlighting the differences in private health insurance policies and the operations of funds.

With cost-of-living pressures expected to continue well beyond 2023, the AMA strongly recommends that Australians check whether they are receiving value for money from their private health insurance.

This 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

It 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. This report card is not intended as a substitute for professional advice. As with any insurance policy, consumers should consider carefully which product is right for them and seek professional advice where necessary.

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



Professor Steve Robson

Federal AMA President

December 2023

¹ The information in the figures in this report is current as at 1 November 2023 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.ombudsman.gov.au, the Australian Prudential Regulation Authority at www.apra.gov.au, and the Australian Bureau of Statistics at www.abs.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 difficult. The federal 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 made 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:

- the federal government, through the Medicare Benefits Schedule (MBS)
- private health insurers
- the patient (through out-of-pocket costs).

Federal, 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.

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

- health insurers do not cover the costs of consultations or treatment provided by a doctor (general practitioner or specialist) outside of hospital as a non-admitted patient
- not all private health insurance policies cover every medical treatment
- insurers can change what is covered by a purchased policy, but they must tell you
- 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 federal government must approve the adjusted premium rate before it comes into effect.

Figure 1 – Rate of increase in cost to consumers of private health insurance premiums from 2009 to 2022 vs. rate of increase to the consumer price index, the consumer health price index, MBS rebates and average weekly earnings over the same period²

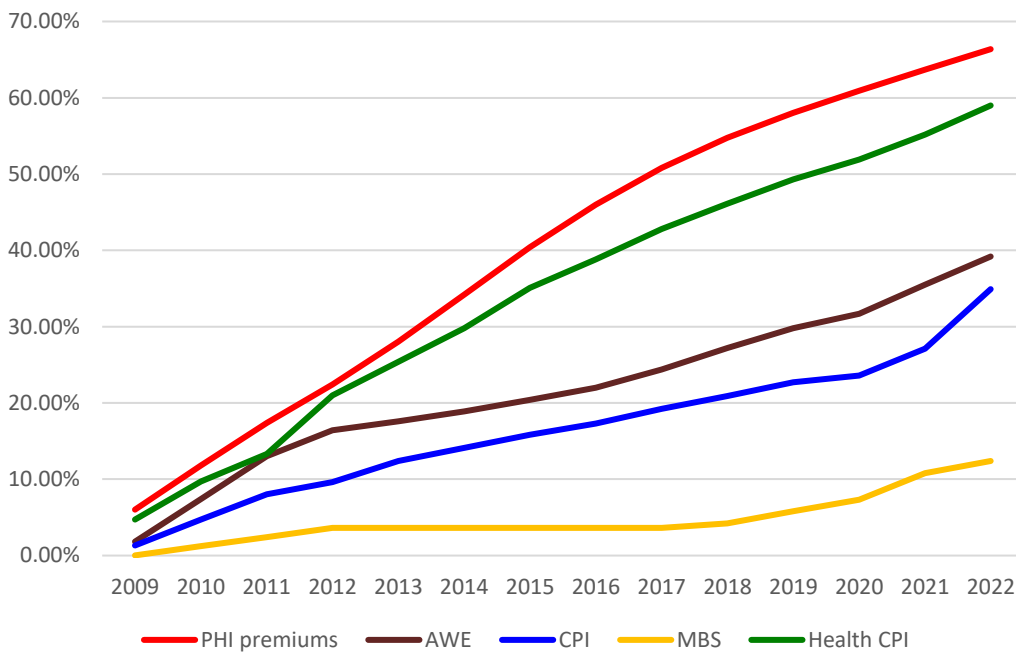


Figure 1 details rates of increase in PHI premiums, average weekly earnings (AWE), the consumer price index (CPI), MBS indexation rates, and the health CPI (a sub-component of the CPI index, which measures increases in a range of health-related costs) between November 2009 and November 2022.

It shows that over time, PHI premiums have risen at a much higher rate than average weekly earnings, rebates for MBS items paid by the Commonwealth Government, the CPI and the health CPI.

² Private health insurance (PHI) increase in premiums: <https://www.health.gov.au/resources/publications/average-annual-price-changes-in-private-health-insurance-premiums>; AWE: <https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia>; MBS: <https://feelist.ama.com.au/resources-ama-gaps-poster>; CPI and Health CPI: ABS data Dec 2009 – Dec 2022 <https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia>

Cover

Doctors working in the private health system sometimes see patients who believe 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 federal government.

When a patient is treated as a private patient, either in a public or private hospital, each of the doctors who is 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.

‘Tiers’ of hospital cover

In 2020, the government mandated that private health insurers classify and market their different hospital policy products as either basic, bronze, silver or gold tier policies depending on the clinical categories of treatment covered under those policies.

The treatments or medical services that a patient is covered for depend on what tier of hospital cover they have purchased.

To be classified as a basic, bronze, silver or gold policy, private hospital insurance policies must, at a minimum, include certain clinical categories of hospital treatment, set by the government, which are listed on the privatehealth.gov.au website.

For example, basic or bronze tier hospital insurance policy products with relatively low policy premium costs include coverage for very few clinical categories of treatment. In other words, basic or bronze tier policies exclude or restrict cover for many types of treatment.

The more expensive silver policy products restrict or exclude cover for a smaller number of clinical treatment categories, and the most expensive ‘gold’ tier policy products cover the widest range of clinical treatments and prostheses/devices.

If a policy meets the minimum requirements of a tier, but also includes additional coverage, then it can be called a ‘plus’ policy – for example, bronze plus or silver plus.

Given this, when choosing a private hospital insurance policy product, it is critical that consumers consider not only the upfront premium cost of the policy, but also whether the policy product covers the kinds of clinical treatment they are likely to need in future.

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.

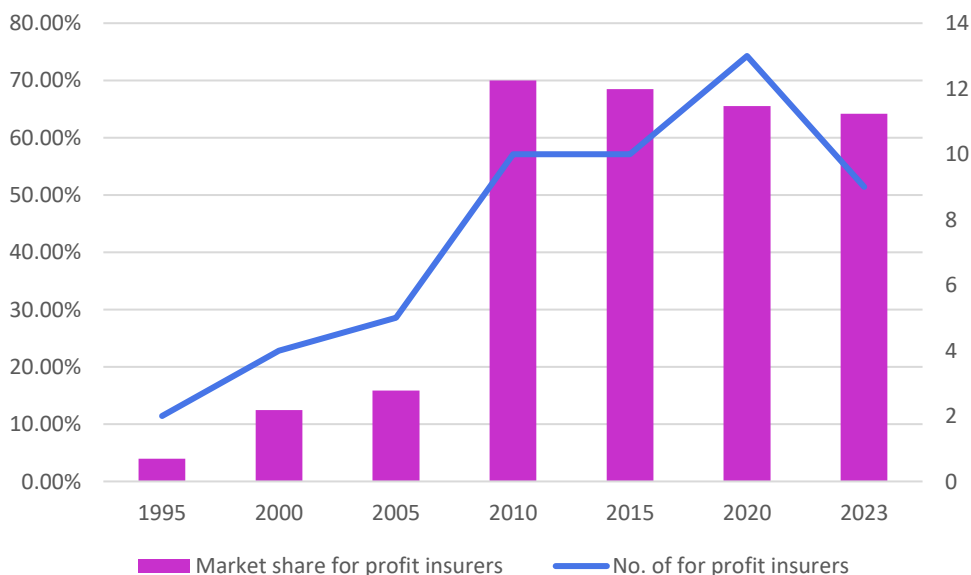
The excess is an amount a patient will pay for hospital-related costs and is separate from any gap payment made for the doctor’s treatment or services. Most policies now include excesses or co-payments.

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 illustrated in Figure 2, there has been a marked change in the composition of private health insurance companies over the last two decades. In 1995, only four per cent of the 49 insurers operating at that time were for-profit companies. Today, there are only 29 insurers (some with several health insurance ‘brands’), nine of which operate on a for-profit basis and cover close to 65 per cent of the insured population.³

Figure 2 – Changes in market share of for-profit health insurance funds – 1995 to 2023⁴



³ <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report> 2022–2023

⁴ <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>

As the proportion of health insurers who operate on a for-profit, rather than non-profit basis increases, insurers 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' and other out-of-hospital medical and allied health services. These programs allow patients to remain at home during all, or some part, of their treatment.

With the largest for-profit insurers having a significant market share each, these big insurers are also making increased use of selective contracting with both hospitals and doctors. Use of contracting arrangements to drive down their costs also enables insurers to influence, and even dictate, the health care pathways and healthcare providers available to their insurance policy holders who are trying to reduce their out-of-pocket gaps.

This shift to larger for-profit insurers has seen some producing sizable profits from the sector for shareholders and offering high levels of remuneration to their top executives.

PAYING FOR MEDICAL CARE

Out-of-pocket costs

Consumers are often 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 generally send them a bill for their services (a fee).⁵ Doctors are free to set their fees at a level they believe is fair and reasonable. These fees take the costs of running a practice into account, including professional indemnity and other insurance, wages, rent, consumables, and other equipment costs.

If you are a patient admitted to hospital (public or private), have private health insurance, 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. Depending on the contracting arrangements they have with your treating doctor, and the private health insurance policy product you have bought, insurers can pay a higher level of benefit than this in specific circumstances. These circumstances are explained under the heading 'no gap and known gap' on page 13.

Inadequate Medicare rebates and private health insurance rebate increases

The MBS is a list of the medical services (known as MBS items) for which the federal government will pay a Medicare rebate, to partially reimburse Australians for 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 reimburse the full cost of medical services. MBS items have not been appropriately indexed (increased to meet healthcare provider costs for doctors) for many years.

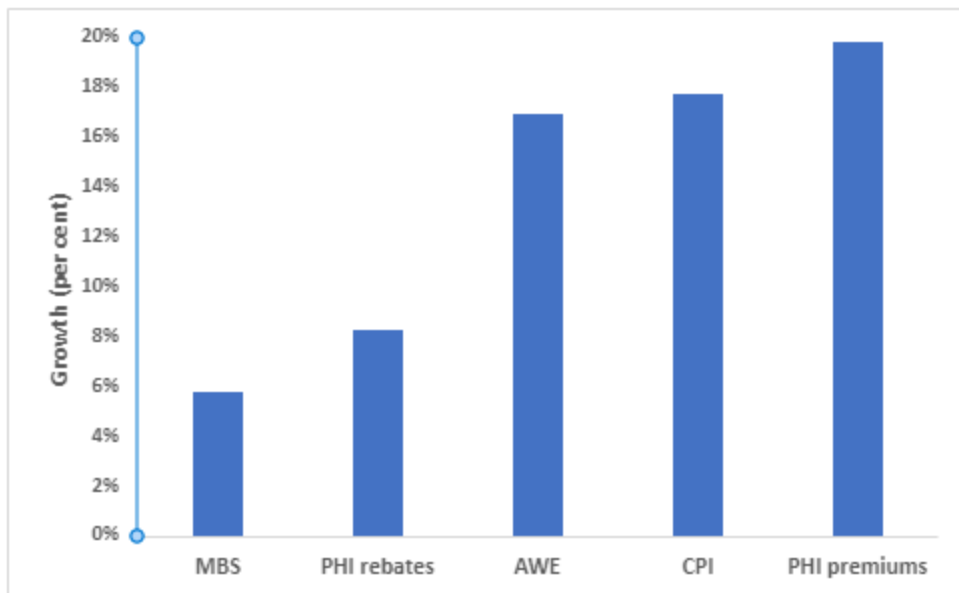
Any gap between the MBS rebate and the doctor's fee and any hospital fees ends up being paid by someone. This can be private health insurers, other funders or the patient.

⁵ Unless the doctor has a no-gap agreement with the patient's insurer, in which case the patient is sent a copy of the payments made by the health fund.

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 in place since 1996, MBS rebates have been raised according to the federal 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 increases to the costs of providing medical care.⁶

Figure 3: Increases to MBS rebates, PHI rebates, CPI, AWE and PHI premiums 2018–2022⁷



In 2013, the federal government froze MBS rebates, meaning they 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, as shown in Figure 3, increases to most private health insurers’ rebates track more closely with increases to MBS rebates than to increases in the premiums they charge consumers.

Medical fees need to cover income, staff wages, medical indemnity insurance, and practice costs (which include rent, medical supplies, telecommunications and equipment). All these costs have risen year on year, even as MBS rebates have not. This has contributed to a growing gap between MBS rebates and the actual costs of providing health care in Australia.

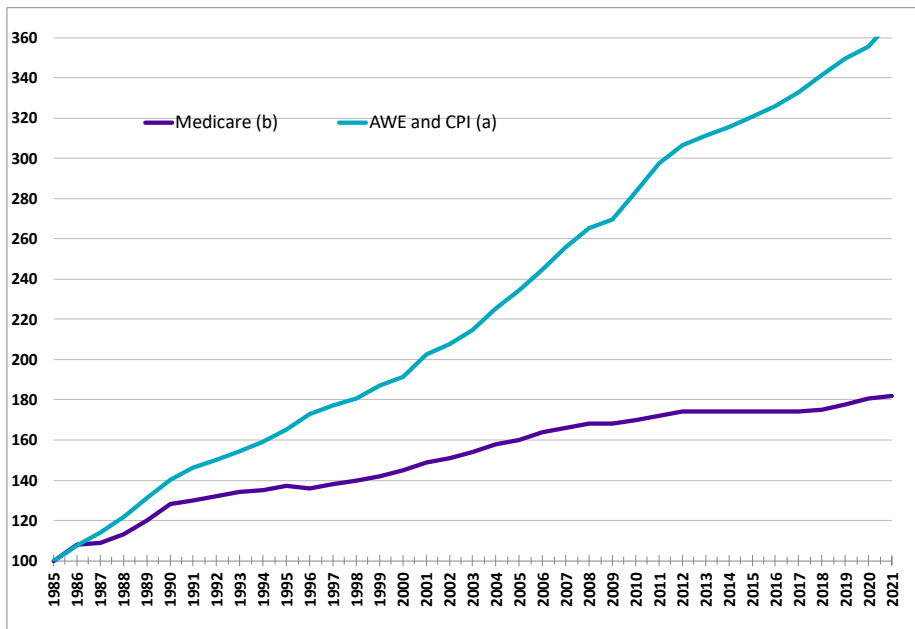
⁶ In the five years from 2016-2020, CPI rose 7.8 per cent, CPI for health alone rose 16.8 per cent but the MBS index only rose 3.7%. ABS statistics from: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/second+level+view?ReadForm&prodno=6401.0&viewtitle=Consumer%20Price%20Index,%20Australia~Jun%202017~Latest~26/07/2017&&tabname=Past%20Future%20Issues&prodno=6401.0&issue=Jun%202017&num=&view=&> MBS indexation from: <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads>

⁷ PHI rebates are calculated from the rebate levels provided by Nib, Medibank and Bupa in the AMA’s Private Health Insurance Report Cards for the period 2018 to 2022. The MBS, CPI, AWE and PHI premium increases are also derived from the AMA Private Health Insurance Report Cards for the period 2018 to 2022.

This is illustrated in Figure 4, which compares increases over time in:

- a composite index of Average Weekly Earnings (70 per cent) and the Consumer Price Index (30 per cent) which reflects the average cost structures of medical practices
- indexation of MBS rebates as determined by the Commonwealth Government.

Figure 4: Why is there a gap?⁸



Changes to Medicare indexation from 1 November 2023

Following a strong and consistent AMA campaign on inadequate [Medicare indexation](#) and the impact of the [Medicare freeze](#) on patients and doctors alike, the federal government announced welcome changes to the Medicare indexation formula in its 2023–2024 budget.⁹

In addition to a one-off top up to Medicare rebates of 0.5 per cent in November 2023, the government announced changes to the formula for Medicare indexation going forward that will take greater account of changes to labour costs, a key component of medical practice costs.

Although the impact of these changes is yet to be felt by patients, it is likely that use of the revised indexation formula from 1 July 2024 will produce greater increases to Medicare rebates than has previously been the case.

⁸ <https://feelist.ama.com.au/resources-ama-gaps-poster>

⁹ <https://www.ama.com.au/ama-rounds/12-may-2023/articles/we-asked-health-budget-and-they-delivered>

No gap and known gap arrangements

Consumers should check whether 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. Around 88 per cent of medical services provided to privately insured patients in hospitals are provided by doctors at 'no gap' rates¹⁰ 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, and
- 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).

Almost 9 per cent of medical services provided to privately insured patients in hospitals are provided at insurers' 'known gap' rates for the medical service.¹¹

No arrangement

It is important to note that it is up to the doctor to decide on a case-by-case basis whether they wish to use an insurer's gap cover (no-gap or known-gap) 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 in this situation, the insurer 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 5 below.

¹⁰ APRA private health insurance membership and benefits statistics June 2023. <https://www.apra.gov.au/publications/private-health-insurance-membership-and-benefits>

¹¹ APRA private health insurance membership and benefits statistics June 2023. <https://www.apra.gov.au/publications/private-health-insurance-membership-and-benefits>

Using a knee replacement (MBS item 49518) as an example, Figure 5 demonstrates these three billing and payment scenarios, where the private health insurer has set a no gap medical benefit of \$2386.75 (including the Medicare benefit), a known gap medical benefit (including the Medicare benefit) of \$2257.85 and a maximum gap amount of \$500.00.

Figure 5: Private health insurer billing scenarios and out-of-pocket costs for a knee replacement¹²

MBS 49518 Fee: \$1,450.55 **Benefit:** 75% = \$1,087.95

Situation	Doctor's fee	MBS Benefit	Insurance medical benefit	Out-of-pocket costs
Doctor accepts insurers no gap medical benefit amount	\$2,386.75	\$1,087.95	\$1,298.80	\$0.00
Doctor accepts insurers known gap arrangement	\$2,757.85	\$1,087.95	\$1,169.90	\$500.00
Doctor does not accept fee cap under insurer's no gap or known gap scheme	\$3,000.00	\$1,087.95	\$362.64	\$1,549.41

Insurance agreements with 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 negotiated a contract with your choice of private hospital, either you will have 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 before treatment, or if you live in a rural area where the nearest private hospital that has an agreement with your insurer 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 on the <https://www.privatehealth.gov.au> website.

¹² MBS Fee and benefit at 1 November 2023; insurer benefit taken from <https://www.bupa.com.au/-/media/dotcom/files/for-provider/bupa-national-medical-no-gap-and-known-gap-scheme-schedule-1-november-2023.xls>

If the private health insurer with whom you currently have hospital treatment insurance does not have an agreement with the hospital in which you wish to be treated, you may want to switch to a different insurer. If you switch to an insurer and policy product that has the same or lower benefits as the plan you are currently on, this should be a relatively easy process, and you should get continuity for waiting periods already served. However, be sure to check for details on what to look out for when changing your insurer. The privatehealth.gov.au website has information on what to look out for when changing your insurer.

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 to support them in understanding the fees and costs associated with that care.

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.

The AMA has worked with key medical organisations to create a comprehensive resource that supports a collaboration between doctors and their patients to ensure fully informed financial consent.

This guide supports patients to be more engaged in conversations with their doctors, with their health fund and with their choice of hospital. It helps create 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, billing practices and medical gaps
- questions for patients to ask their doctors about costs.

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 Finder¹³ to help Australians understand the cost of common medical procedures provided by specialist medical professionals.¹⁴

This tool can be used to:

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

¹³ <https://www.health.gov.au/resources/apps-and-tools/medical-costs-finder#what-the-medical-costs-finder-is>

¹⁴ <https://www.greghunt.com.au/new-website-to-improve-consumer-understanding-of-medical-costs/>

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

While this can help you better understand what is typically paid, it does not provide you with specific information about the medical fees that will be charged for your procedure which will vary depending on your age, risk factors and any complicating issues. It's therefore important to note that any indicative fees published on the site by medical practitioners are not a substitute for a quote specific to your individual circumstances.

Consumers should note that while a patient's out-of-pocket costs come from a doctor's fee and the benefit paid by a fund, benefit rates are not uniform across insurers, procedures, states and territories, or 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.¹⁵

Consumers should also be aware that the government's Medical Costs Finder website¹⁶ does not include any information on how long you are likely to wait for elective surgery or an outpatient clinic appointment at your local public hospital — important information to have 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 public hospital.

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. Given the limitations of the government website, the best way to fully understand your likely out-of-pocket costs is to discuss your procedure directly with your medical practitioner and ask any relevant questions, so that your financial consent to the procedure (or decision to reconsider your options) is fully informed.

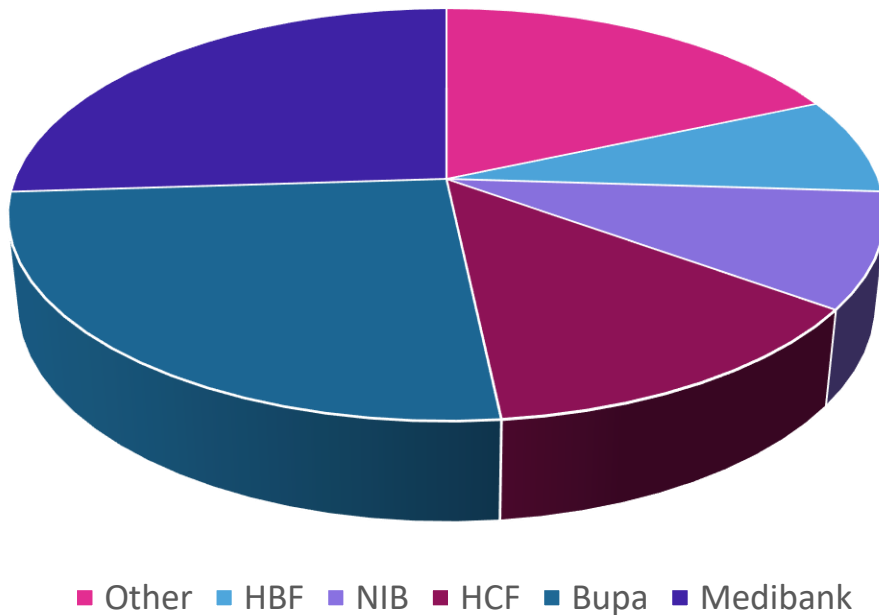
To that end, the AMA strongly recommends that patients refer to its [Informed Financial Consent Guide](#) so they fully understand the financial issues relevant to their individual situation.

¹⁵ Doctors are free to decide whether to participate in a particular fund's gap cover arrangements. Several factors can affect that choice. These include whether a fund has a substantial share in the health insurance market of a particular state, amounts paid under the gap arrangements compared to the doctor's chosen fee, and the details of the insurer's gap cover arrangements, including any administrative arrangements.

¹⁶ <https://www.health.gov.au/resources/apps-and-tools/medical-costs-finder#what-the-medical-costs-finder-is>

WHAT YOUR PREMIUMS GIVE BACK

Figure 6: Insurer market share 2022–2023



As shown in Figure 6, the five largest health insurers have a combined market share of more than 81 per cent. They also contributed to more than 79 per cent of total health fund benefits paid in 2022–23.¹⁷ 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 hospitals).

Private health insurers will generally aim to set premium levels to cover the expected costs of benefits plus the insurer's management costs; for-profit insurers will also factor in their desired profit margins. However, the benefit that an insurer may agree to pay varies by insurer, policy, procedure and whether the treatment is 'planned' or required thanks to an accident or emergency. The [privatehealth.gov.au](https://www.privatehealth.gov.au) website has [information for consumers](#) on how insurers deal with unplanned treatment and complications, and we recommend consumers read it.

¹⁷ <https://www.apra.gov.au/sites/default/files/2023-10/Operations%20of%20Private%20Health%20Insurers%20Annual%20Report%202022-23.xlsx>

Figure 7: Benefits paid for select admitted medical services by different private health insurers at 1 November 2023

MBS Item	MBS Description	MBS Fee	Bupa no gap	HCF no gap	AHM/ Medibank Private	NIB no gap	AHSA no gap (NSW)	HBF no gap (WA)	Var lowest to highest
326	Attendance by a consultant physician	\$205.20	\$234.85	\$246.25	\$248.30	\$239.20	\$231.70	\$256.80	\$25.10 11%
12203	Overnight Investigation for sleep apnoea	\$647.20	\$770.75	\$770.15	\$783.00	\$784.75	\$740.30	\$807.65	\$67.35 9%
13950	Cytotoxic Chemotherapy	\$118.90	\$143.85	\$151.00	\$140.30	\$135.20	\$130.60	\$152.20	\$21.60 17%
16519	Uncomplicated Delivery (of baby)	\$763.85	\$2,177.40	\$2,199.90	\$2,077.00	\$1,707.20	\$1,750.50	\$2,227.55	\$520.35 30%
16522	Complicated Delivery (of baby)	\$1,793.40	\$2,549.55	\$2,564.55	\$2,546.80	\$2,531.00	\$2,319.90	\$2,818.30	\$498.40 21%
18216	Epidural anaesthesia during labour	\$209.05	\$338.80	\$338.65	\$329.10	\$325.70	\$322.60	\$336.75	\$16.20 5%
30445	Cholecystectomy	\$915.90	\$1,307.40	\$1,300.60	\$1,303.70	\$1,099.05	\$1,341.70	\$1,240.75	\$242.65 22%
30648	Femoral or Inguinal Hernia	\$511.35	\$728.80	\$726.10	\$736.35	\$691.10	\$967.30	\$695.90	\$276.20 40%
30720	Appendicectomy	\$490.30	\$703.45	\$696.25	\$710.95	\$662.65	\$696.10	\$667.35	\$48.30 7%
31512	Breast, malignant tumour, removal	\$715.60	\$1,049.30	\$1,016.15	\$977.60	\$967.20	\$981.40	\$960.25	\$89.05 9%
32139	Haemorrhoidectomy	\$404.75	\$572.65	\$554.50	\$576.10	\$523.70	\$663.80	\$543.15	\$140.10 27%
32222	Colonoscopy	\$368.00	\$510.65	\$504.15	\$489.45	\$476.20	\$479.10	\$490.70	\$34.45 7%
32500	Varicose Veins	\$120.85	\$186.65	\$176.45	\$188.95	\$164.50	\$177.20	\$162.80	\$26.15 16%
35657	Vaginal Hysterectomy	\$742.70	\$1,217.85	\$1,203.15	\$1,216.40	\$1,119.60	\$1,120.10	\$1,323.75	\$204.15 18%
37623	Vasectomy	\$253.05	\$389.60	\$384.65	\$409.95	\$386.45	\$374.10	\$344.40	\$65.55 19%
39331	Carpal Tunnel Release	\$304.65	\$523.45	\$499.65	\$510.40	\$461.80	\$462.40	\$490.50	\$61.65 13%
39710	Craniotomy	\$2,667.45	\$4,379.85	\$4,374.60	\$4,259.65	\$4,044.10	\$4,048.70	\$4,296.20	\$335.75 8%
41789	Tonsils or Tonsils and Adenoids	\$325.45	\$599.15	\$598.85	\$537.20	\$488.10	\$540.30	\$556.35	\$111.05 23%
42702	Cataract Surgery	\$837.20	\$1,341.40	\$1,297.65	\$1,303.05	\$1,266.40	\$1,331.70	\$1,321.20	\$75.00 6%
46340	Synovectomy of wrist	\$436.20	\$680.85	\$676.10	\$732.80	\$657.50	\$651.90	\$639.25	\$93.55 15%
49518	Knee Replacement	\$1,450.55	\$2,386.75	\$2,291.85	\$2,308.10	\$2,228.15	\$2,696.70	\$2,296.15	\$468.55 21%
1	2	3	4	5	6	7	8		

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 out-of-pocket cost, but the reality is that 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.

Figure 7 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 listed insurers, but it is important to note that the table does not represent benefits paid by the entire industry.

Figure 7 also illustrates the significant variation between the amounts different insurers will pay for the same procedure. For example, for MBS Item 16519, there's a 30 per cent variation (\$520.35 difference) between the benefits paid by the insurer that pays the most, and the insurer that pays the least. These differences contribute to differing out-of-pocket costs paid by patients and point to the importance of looking beyond the premium charged for different policy products to ensure you get value for money.

It is also important to note that these payments relate to the relevant MBS item and insurer description. For any particular procedure or service, such as a knee replacement or other surgery, additional MBS items may be required (for example, pathology, diagnostic imagery, and anaesthetics) or for any other doctors involved.

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

State-based differences in insurer gap schemes

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

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 service charges (doctor's fees for service) provided at no gap.

For example, the Australian Health Service Alliance benefit for cataract surgery (MBS Item 42702) in New South Wales is \$1,331.70. However, if you are in South Australia, that benefit is \$1,158.30. This is a difference of \$173.40 or 13 per cent.

In addition to varying the benefit paid, different insurers operating in the same state or territory can have a higher or lower percentage of medical and hospital services covered at no gap. 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, so it is important to compare and benefits and gap schemes of different insurers operating in your state or territory before selecting a private health insurance policy product.

TRENDS IN PRIVATE HEALTH INSURANCE

Impact of the COVID-19 Pandemic

Elective surgery restrictions

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 have long waiting lists, supply and workforce issues, all of which are likely to continue into the future.

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 depending on the public health measures being taken to counteract the pandemic.

These restrictions and reductions led to an overall decrease in admissions from elective surgery waiting lists and impacted waiting times for elective surgery.¹⁸

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.

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 restrictions¹⁹ and many have taken a range of steps to deliver on this promise and support 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)²⁰
- providing money directly back to members.

The most recent ACCC report on private health insurers²¹ noted that as of 30 June 2023, health insurers had returned most of the savings they made because of claims not being made during the worst of the pandemic, and/or have plans to do so during 2023–24. The ACCC has stated that it expects insurers to keep on returning these savings to policyholders 'until they no longer retain any financial benefits from claims that were missed due to COVID–19 restrictions and are not expected to materialise later' and that it will continue to monitor this issue.²²

¹⁸ <https://www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery>

¹⁹ <https://www.privatehealthcareaustralia.org.au/health-funds-committed-to-providing-financial-relief-for-members-impacted-by-covid-19/>

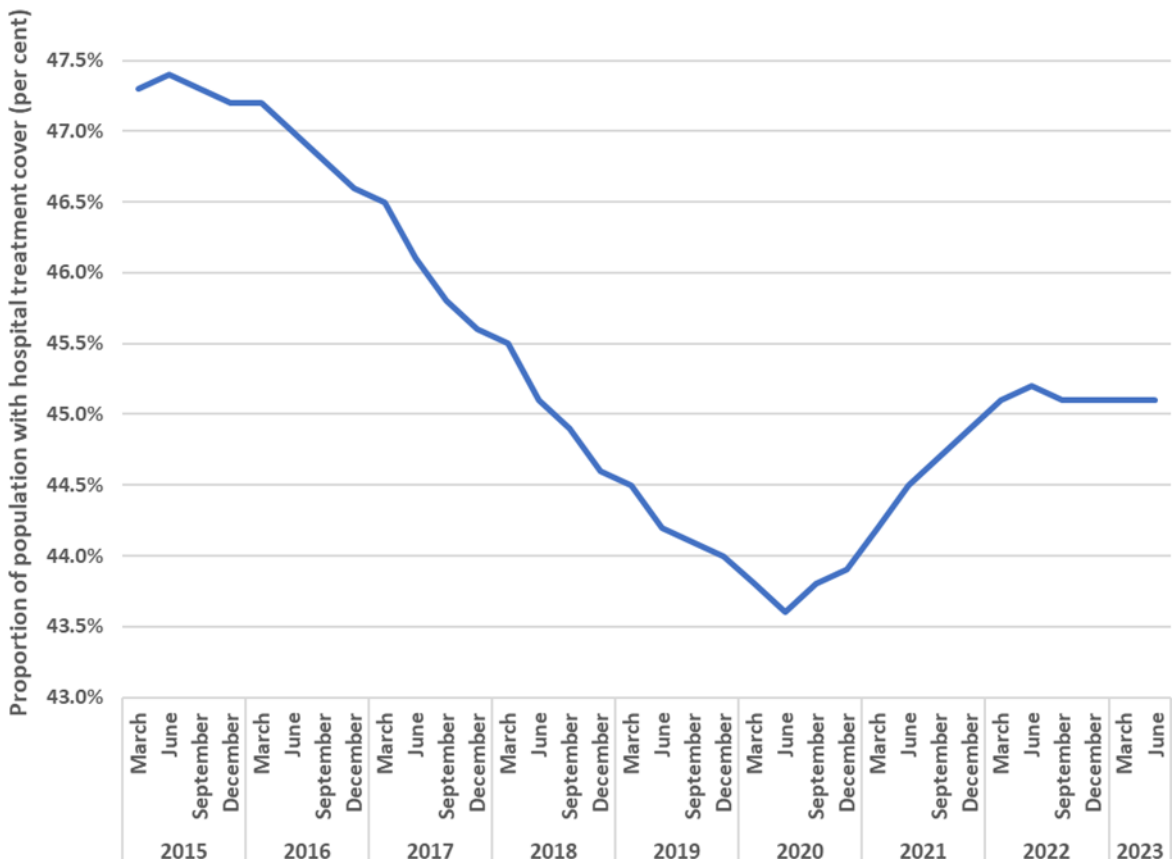
²⁰ <https://www.privatehealthcareaustralia.org.au/health-funds-committed-to-providing-financial-relief-for-members-impacted-by-covid-19/>

²¹ <https://www.accc.gov.au/about-us/publications/serial-publications/private-health-insurance-reports/private-health-insurance-report-2022-23>

²² <https://www.accc.gov.au/about-us/publications/serial-publications/private-health-insurance-reports/private-health-insurance-report-2022-23>, p. v.

Private health insurance performance

Figure 8: Private Health Insurance - proportion of population with hospital treatment cover²³



In the 12 months following the release of the AMA’s 2022 Private health insurance report card there has been a net increase of 270,160 people with hospital treatment insurance. Although this represents an increase of 2.3 per cent in the absolute number of people insured, when we factor in population growth, it also represents a slight drop of 0.1 per cent in the proportion of the population insured.

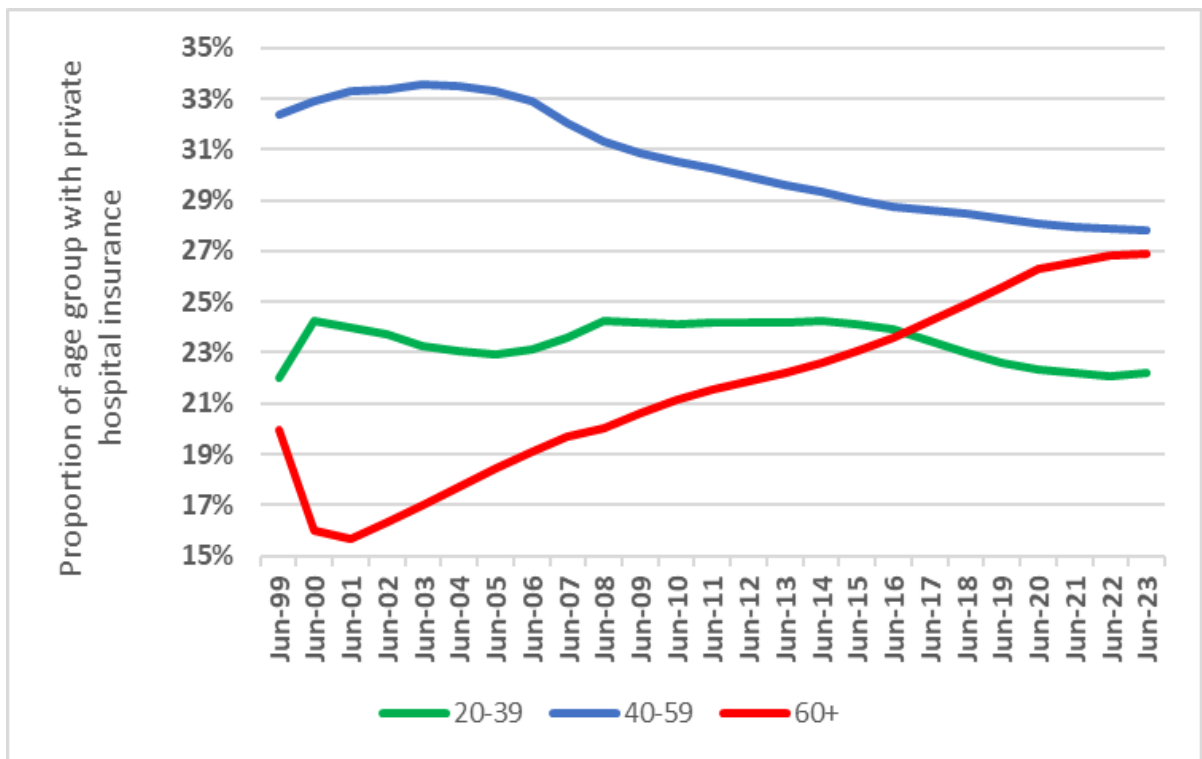
Although Figure 8 illustrates a steep drop in the proportion of the population with private hospital insurance between the second half of 2015 until mid-2020, not all age cohorts dropped private health insurance at the same rate. For example, between June 2019 to June 2020 the number of people aged over 65 with hospital treatment policies increased by 71,496 or 0.71 per cent.

²³ [APRA Statistics](#) Quarterly private health insurance membership coverage 2015-June 2023.

Increases in the proportion of people with hospital insurance who are from more senior age groups has consequences for policy premiums, because insurers pay out a lot more in benefits to these age group than they do for younger cohorts of insured people.

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. At age 75 and over, these figures increase dramatically: those aged 75–84 received 260 per cent, while the insured aged 85 years or older received a staggering 310 per cent of the average benefits.²⁴

Figure 9: Demographics of the private hospital insured population June 2009–June 2023²⁵



²⁴ [APRA Statistics](#), Insurance, membership and benefits statistics, December 2018. "AUSTRALIA" worksheet, Page 2, "Hospital Treatment and General Treatment Combined"

²⁵ [APRA Statistics](#) Private Health Insurance Membership Trends 2001–2023.

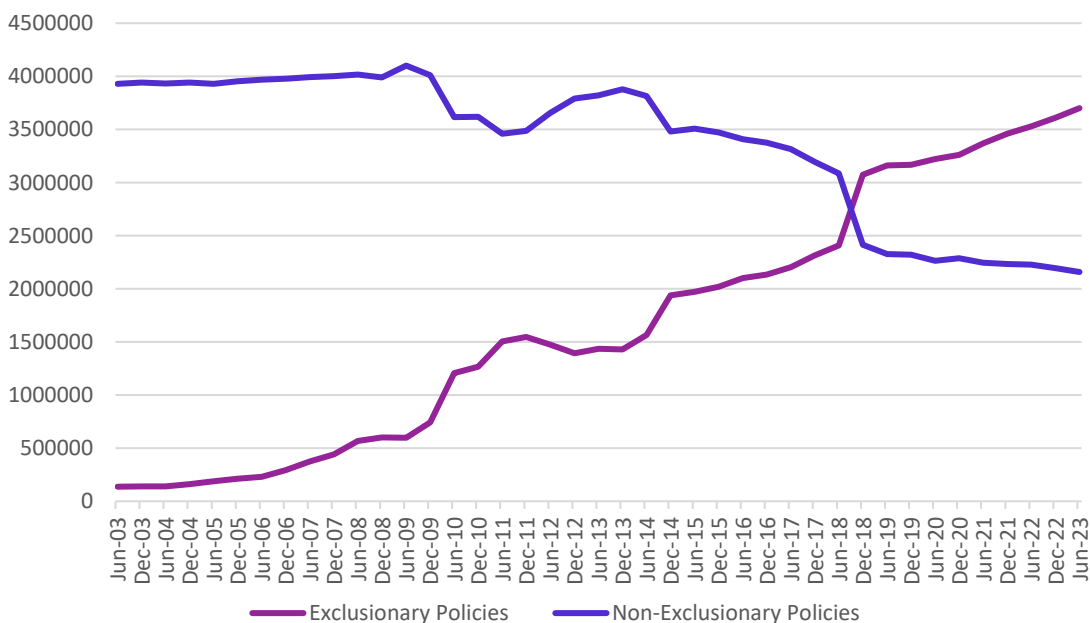
To cover those additional costs and keep insurance affordable for seniors (most particularly retirees, many of whom may rely on the pension, or on lower incomes than working-aged people) insurers spread the costs by raising premiums for all age groups.

Since June 2021 there has been a rise in the number of people taking up private health insurance policies, possibly because of pandemic-related increases to public hospital waiting lists. As shown at Figure 9, the rate of increase in the over 60 age group taking out private hospital insurance has slowed considerably over the past year, as has the decline in the proportion of the hospital-insured who are in 40–59 age group. Nevertheless, it is likely that the 60+ age group will become the largest insured age cohort in the foreseeable future.

Change in exclusions

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 excluded condition.

Figure 10: Change in private health insurance hospital treatment²⁶ exclusionary and non-exclusionary policies June 2003–June 2023²⁷



²⁶ Includes hospital treatment only and hospital/general treatment combined policies

²⁷ [APRA Statistics](#), Private Health Insurance Membership and Benefits - Part 1 Policies and Insured Persons 2003 – 2023.

Another useful measure for consumers to understand the value of private health insurance is examining whether their policy contains exclusions. Only 15 years ago, virtually no policies had exclusions, but in 2018, for the first time, most policies contained exclusions. As shown in Figure 10, the trend to an increasing proportion of policy offerings containing exclusions has continued from this point.

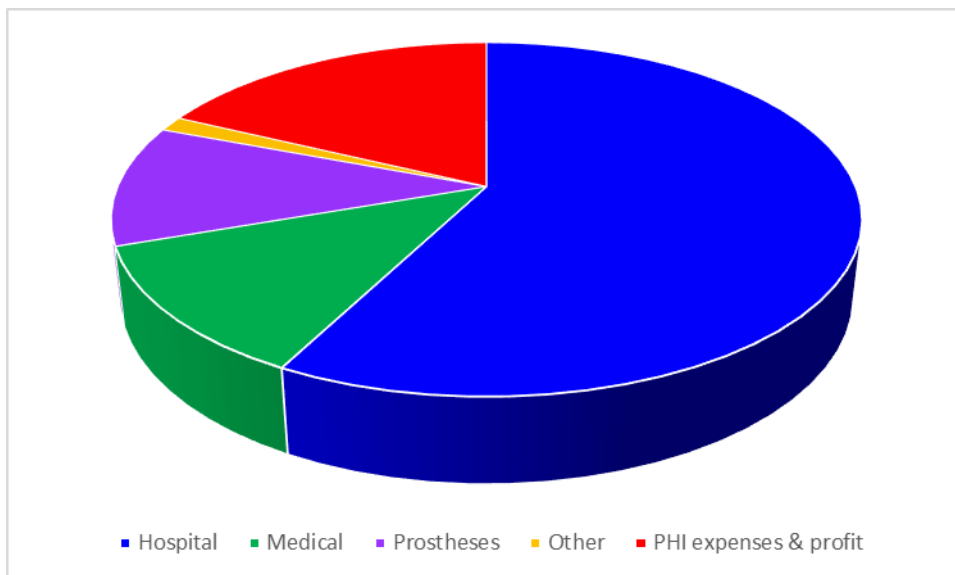
Private health insurer expenses

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.

Regardless of whether a private health insurer is for-profit or not-for-profit they have several 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
- management costs: the proportion of policy premiums that are used to manage the business of the fund.

Figure 11: Health insurer distribution of hospital policy premium revenue 2022–23²⁸



²⁸ [APRA Statistics](#). Private Health Insurance Membership and Benefit Statistics, September 2022 to June 2023.

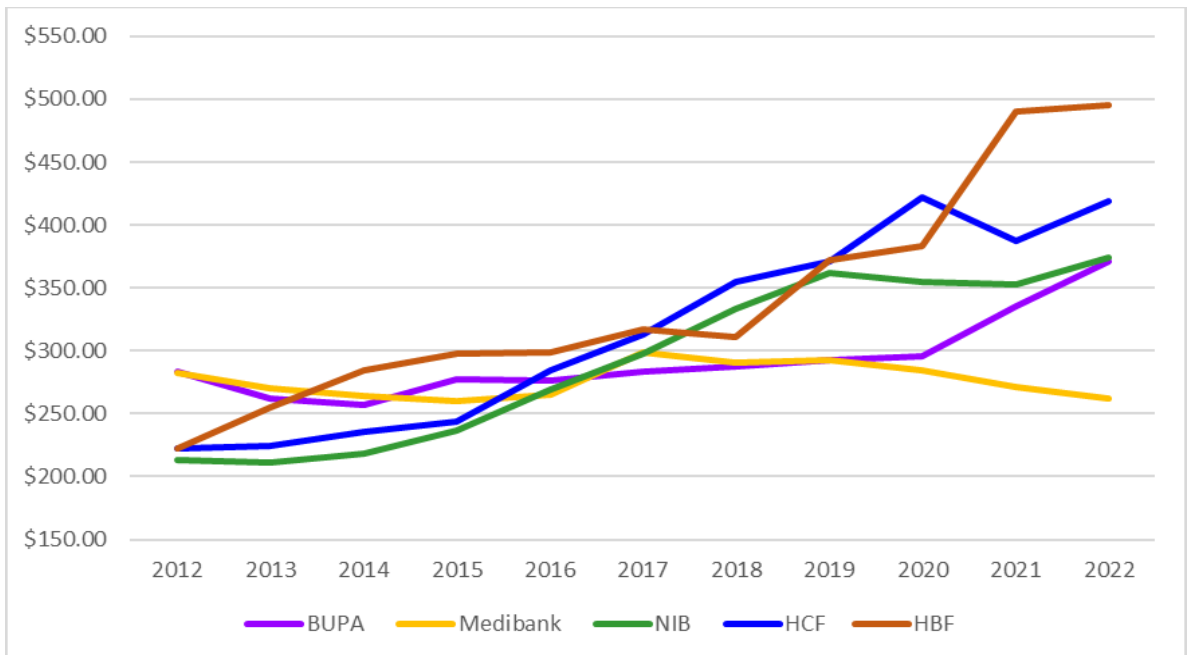
All funds have management expenses and depending on their position in the market and whether they are for-profit, they can have varying marketing costs, staff salaries, overheads like rent and claims handling expenses, and profit margins that need to be built into these expenses.

Figure 11 shows the aggregate distribution of hospital policy premium revenue for the industry in the 2022–23 financial year, between benefits for the costs of hospital stays, benefits for medical treatment and prostheses in hospital, and insurer expenses (including management expenses) and profit.

Overall, private health insurer profits have increased considerably over the last year or so, as elective surgeries in private hospitals resume following the disruptions caused by the pandemic. For example, for the 2020–21 financial year, gross insurer surplus (hospital premiums paid in less hospital benefits paid out) for hospital insurance were about 12.5 per cent of hospital insurance premiums paid. However, for 2022–23, the gross surplus for hospital insurance represented around 18 per cent of hospital premiums paid — a very large difference in gross surplus from 2020–21 in the order of \$1.36 billion dollars.²⁹

Management expenses

Figure 12: Change in management expenses per average policy for the largest five private health insurers (by market share) 2012–2022



²⁹ APRA Statistics. Private Health Insurance Membership and Benefits Statistics, September 2020 to June 2023.

Figure 12 illustrates the change in the management expenses per average policy of the five largest insurers by market share between the 2011–12 and 2021–22 financial years. The expenses are as reported in the Private Health Insurance Ombudsman State of the Health Fund Reports and are not adjusted for inflation.³⁰

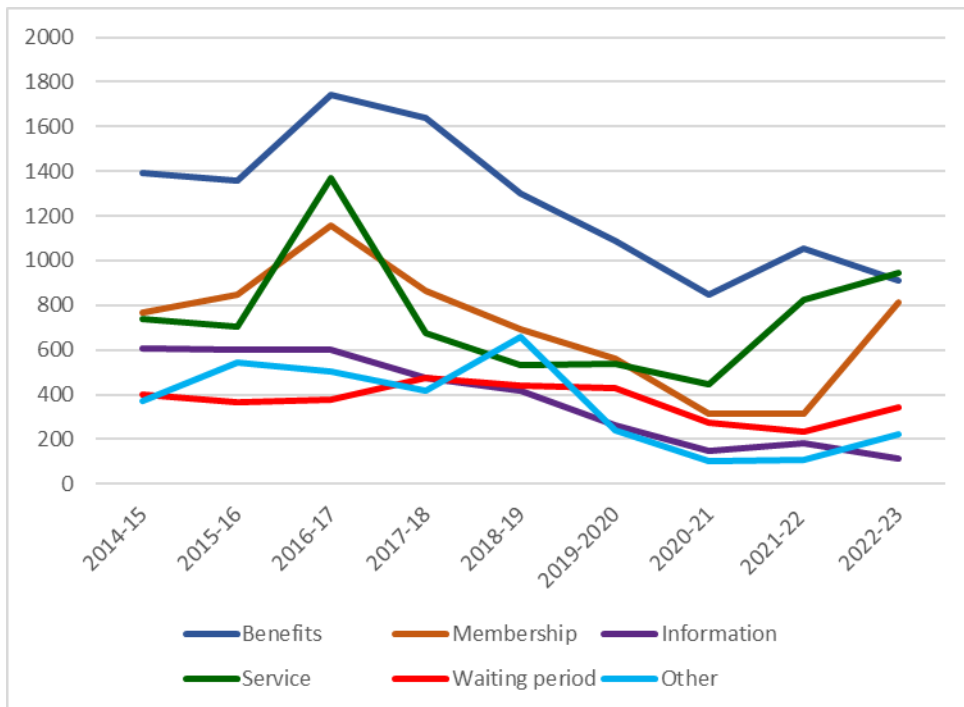
The amount paid by insurers for management expenses can vary considerably, with some insurers paying more than 15 per cent of their contribution income. However, for the 2022–2023 financial year, the industry average was 10.8 per cent, up 0.9 per cent on the 2021–22 industry average of 9.9 per cent.³¹

Insurers with relatively high management expenses pay out a smaller proportion of premiums on members’ claims for admitted hospital treatments than insurers with lower management expenses. 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.

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.

Figure 13: PHIO complaints, by issue, 2014–15 to 2022–23³²



³⁰ Private Health Insurance Ombudsman State of the Health Funds Reports 2011–2022. Note that there is a considerable delay in publication of these reports, so these figures relate to the previous year – e.g., the latest report for 2022 provides data for the 2021–22 financial year.

³¹ <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>, 2021–2022 and 2022–2023.

³² Private Health Insurance Ombudsman State of the Health Funds Reports, Commonwealth Ombudsman Annual Report additional Private Health Insurance Information), Private Health Insurance Ombudsman Quarterly Bulletins

The PHIO protects the interests of people covered by private health insurance. It carries out this role in several 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.

As shown at Figure 13, complaint statistics published by the PHIO suggest that despite fluctuations in total numbers, the greatest level of problems that consumers experience continues to be across a small number of constant issues. In recent years, the highest number of complaints have centred on benefits (non-payment or delayed payment, gaps paid), membership issues, service-related issues, followed by waiting periods, and information provided that doesn't meet consumer needs.

The PHIO has noted that the recent uptick in complaints about membership and service-related issues were in part related to the Medibank data breach that occurred in October 2022. They were also related to students experiencing membership cancellation problems with Peoplecare Health Limited. Most of these cancellations related to delays students experienced in accessing refunds for Overseas Student Health Cover they could not use thanks to pandemic-related border closures.³³

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, most consumers can find it challenging to understand the detail about a policy whether it is presented online or in brochures.

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 use the [private health insurance complaint form](#) available on the PHIO website.

Private Health Information Statement (PHIS)

Since 1 April 2020, health insurers have been required to send members an annual statement in the form of a PHIS, summarising what their policy does and does not cover, and to send it again each time their policy changes.

When choosing between different private hospital insurance policy products, consumers should also be able to download a PHIS for each policy product an insurer offers from the insurer's website. People can also search for and compare a PHIS for every available private health insurance policy product in Australia on privatehealth.gov.au website.

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. However, to obtain the full details for the insurance policy you should still contact the insurer and be sure to read any associated terms and conditions or fund rules documents, as they usually contain important details about the circumstances in which the insurer will pay particular benefits.

³³ https://www.ombudsman.gov.au/_data/assets/pdf_file/0011/301205/PHIO-QU-April-June-2023-and-Annual-Summary.pdf

MORE INFORMATION ABOUT PRIVATE HEALTH INSURERS AND THEIR PRODUCTS

AMA resources

The AMA has several 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](#)
- [AMA guide for patients on how the health care system funds medical care](#)

Federal government information

The federal government's privatehealth.gov.au website provides:

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

Medical Cost Finder

The federal government has developed an online tool — the [Medical Costs Finder](#) — 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.

Private Health Insurance Ombudsman – PHIO

The Private Health Insurance Ombudsman (PHIO) protects the interests of people covered by private health insurance. It carries out this role in several ways, including an independent complaint handling service.

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 [PHIO website](#).

MBS Online

You can search the MBS for all the latest fees and information at [Medicare Benefits Schedule \(MBS\) Online](#) which contains a listing of the Medicare services subsidised by the federal government.

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2023

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