AMA

PRIVATE HEALTH INSURANCE REPORT CARD 2024

Contents

Introduction

Australia's health system is world leading. In my opinion, part of that is due to the critical balance between public and private care that we enjoy. Not only does a strong private sector help the sustainability of our public health system, but private healthcare is critical to Australians receiving timely, expert care in the location of their choosing, with the practitioner of their choice. It is an arm of our health system worth protecting.

The private health sector spent a lot of time in the headlines during 2024 as contract disputes between several insurers and private hospital groups spilled into the public domain and the Department of Health and Aged Care's Private Hospital Health Check showed some hospital operators are under significant financial pressure.

This has clearly undermined consumer and doctor confidence in a product that is critical to the overall performance of our health system.

Over several years, many private hospitals have closed or downgraded their services in critical areas such as maternity, mental health, and reconstructive surgery, leaving patients struggling to access the services they need, and doctors struggling to provide care for their communities.

Australian private health insurers again reported significant profits for the 2024 financial year, with gross margins[1] from hospital treatment policy premiums alone approaching 16 per cent of hospital policy premiums paid. In addition, industry average management expenses were 11.5 per cent, up from 10.8 per cent in the 2023 financial year.

Over the five-year period to June 2024, net private health insurance profits (including net private health insurance investment income) increased by 47.8 per cent, while management expenses rose by 50.5 per cent.

Evidence of insurers avoiding ministerial scrutiny of premium increases by closing cheaper policies to new customers and releasing similar but much more expensive policies was deeply concerning.

Practices like this have real impacts on our health system. Over the past few years more than 400,000 Australians have downgraded the level of private health insurance cover they hold, which means many are no longer covered for the kinds of care they may need in private hospitals, leaving patients underinsured, and placing greater pressure on our public hospitals.

The AMA has been highlighting the need for reform of the private health insurance system for more than a decade and these and other issues clearly demonstrate the system is in trouble and needs real reform.

[1] Gross margins for hospital treatment policies reflect the difference between the amount consumers pay in to private health insurers in the form of premiums for hospital treatment insurance policies, and the amount consumers receive back in the form of benefits for hospital treatment.

We need a sustainable system, overseen by a fit-for-purpose and independent Private Health System Authority, that ensures patients have access to affordable private health insurance and can receive treatment when and where they need it.

A viable private health insurance system must provide value for money to patients. Patients rightfully have an expectation to receive real value from their private health insurance policies, and the AMA believes the government should mandate a minimum amount that every insurer is required to return to patient care in the form of claims benefits.

The AMA's 2024 Private Health Insurance Report Card examines the issues highlighted above and aims to help consumers check whether they are receiving value for money from their private health cover, by highlighting what to look for when searching for the right cover, and differences between policies and the operation of funds.

It provides a comparison of the proportion of in-hospital medical costs covered by each fund for common hospital procedures. The significant differences in the level of benefits provided by various insurers for these procedures highlights the fact that when choosing a private hospital treatment insurance policy, consumers need to look beyond a comparison of the policy premiums charged for these products by different funds. I hope this report encourages Australians to review their private health insurance policy to ensure it meets their needs.[2]

I am hopeful the government's decision to commission the Private Health CEO forum to develop short-term and long-term proposals to strengthen the private health system is an important step towards real reform — reform that properly balances the needs of hospitals, suppliers, doctors, insurers, and most important of all — patients.

Dr Danielle McMullen
AMA PRESIDENT
February 2025

[2] Consumers should note that the information provided in this document is not tailored for individual circumstances and is not intended as a substitute for professional advice. As with any insurance policy, consumers should consider carefully which private health insurance product is right for them and seek professional advice where necessary.

Private health insurance in Australia

How healthcare is funded

Working out the right private health insurance policy 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 healthcare 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.

Once each year, private health insurers can apply to the minister for health and aged care for approval to increase the premiums for their policy products. This

is called the 'premium round process'. It usually begins late in the year, with insurers submitting bids for the premium increases they want for the following year, supported by documentation aimed at justifying the increases requested in their bids. If the minister is satisfied with these bids, premium increases are usually announced the following February or March, to take effect on 1 April. However, if the minister considers the price increases requested for any health insurance policy product to be unjustified, he or she is empowered to reject the relevant bid and ask the insurer to submit a more reasonable price increase request.

Since the start of December 2024, the Minister for Health and Aged Care has written to health insurers twice to request they resubmit premium increase bids, on the grounds that requested premium increases are too high, and not in the interest of consumers.[3]

Figure 1: Rate of increase in cost to consumers of private health insurance premiums from 2008 to 2023 vs rate of increase to the Consumer Price Index, the Consumer Health Price Index, MBS rebates and average weekly earnings over the same period.[4]

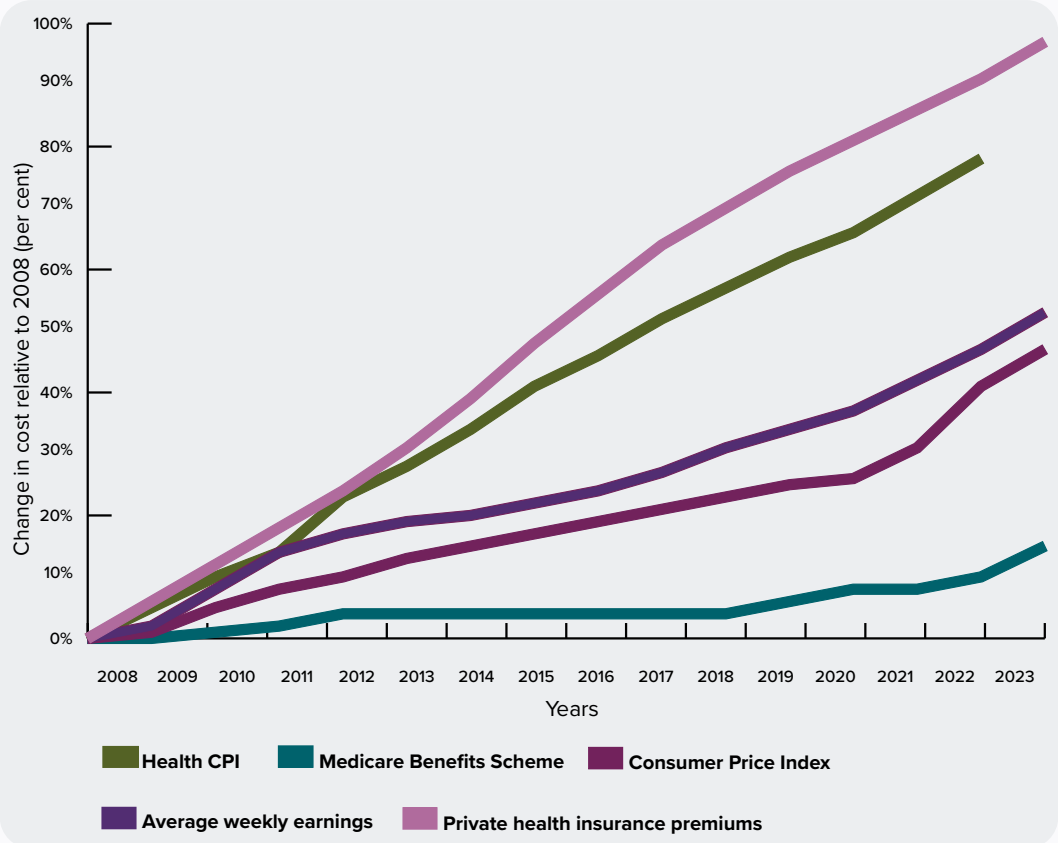


Figure 1 details rates of increase in PHI premiums, average weekly earnings (AWE), the Consumer Price Index (CPI), MBS indexation rates, and the Health CPI (a sub-component of the CPI index, which measures increases in a range of health-related costs) between November 2008 and November 2023. It shows that

[3] https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-press-conference-9-december-2024; https://www.abc.net.au/news/2025-01-15/mark-butler-rejects-private-health-insurers-proposed-premiums/104820310

[4] 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://feeslist.ama.com.au/resources-ama-gaps-poster; CPI and Health CPI: ABS data Dec 2008 – Dec 2023 https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia

over time, PHI premiums have risen at a much higher rate than average weekly earnings, rebates for MBS items paid by the federal government, the CPI, and the health CPI.

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 (the MBS 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 hospital accommodation and any other services it provides.

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 the 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 benefits.

'Tiers' of hospital cover

In 2020, the government mandated 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 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 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.

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

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.

Private health insurer contracts

There has been a marked change in the composition of private health insurance companies over the past three decades. In 1995, only four per cent of the 49 insurers operating at the time were for-profit companies. Today, there are only 29 insurers (some with several health insurance brands), eight of which operate on a for-profit basis and cover close to 64 per cent of the insured population.[5]

As the proportion of health insurers who operate on a for-profit, rather than non-profit basis has increased, insurers have continued 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 healthcare 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 or control the healthcare pathways and healthcare providers available to their insurance policy holders who are trying to reduce their out-of-pocket costs.

[5] APRA annual private health insurance membership and benefits statistics 2023–24; https://www.apra.gov.au/register-of-private-health-insurers

Paying for medical care

Out-of-pocket costs

Consumers are often very concerned 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).[6] 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 pages 13–14.

[6] That is, 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.

Inadequate Medicare rebates and private health insurance rebate increases

The Medicare Benefits Schedule (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 provided by a medical practitioner during an episode of hospital treatment when the patient is admitted as a private patient.

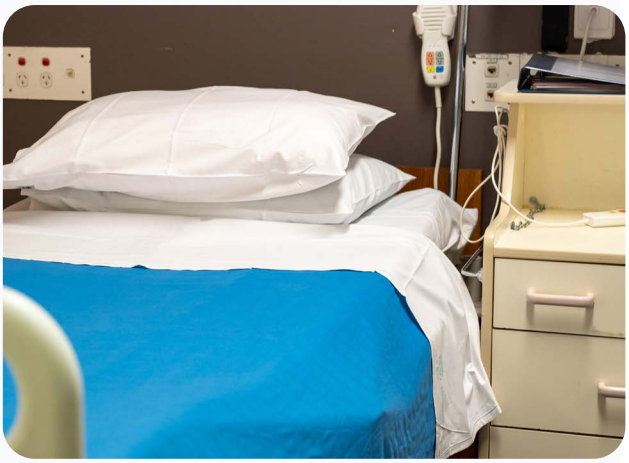
The MBS was not designed to reimburse the full cost of medical services. MBS items have not been appropriately indexed (increased to meet healthcare provider costs for doctors) for many years.

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.

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.

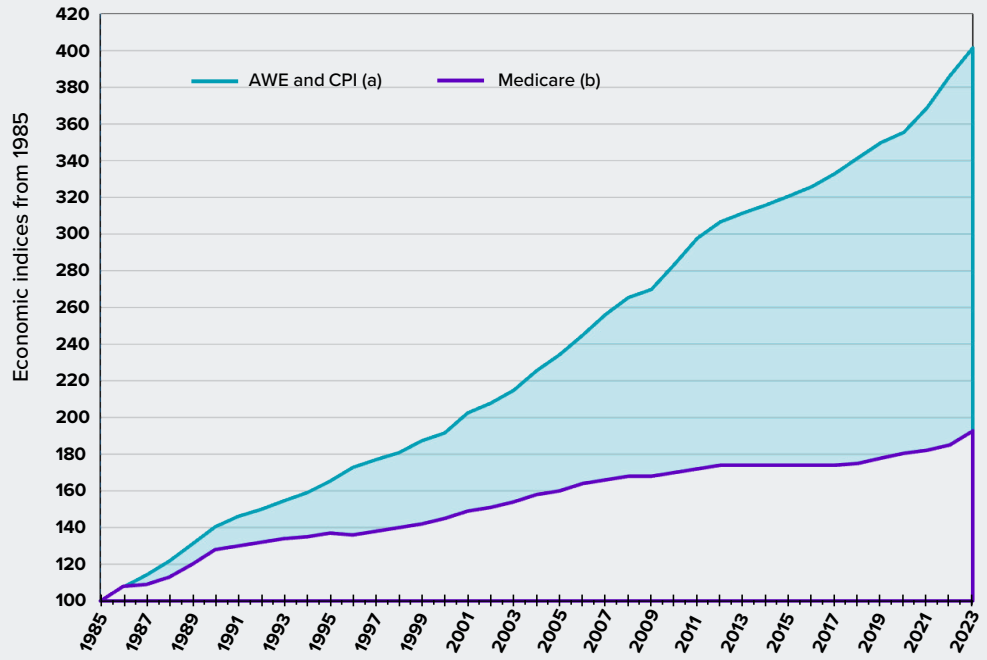
Under an indexing process in place from 1996 until November 2023, MBS rebates have been raised according to the federal government's Wage Cost Index, a combination of indices relating to wage levels and the Consumer Price Index (CPI). This indexation has been considerably less than CPI rates, let alone increases to the costs of providing medical care.[7]

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 healthcare. The freeze was lifted (but not for all items) in 2019. The impact of inadequate indexation followed by a freeze of MBS rebates was compounded by the fact most private health insurers' rebates track more closely with increases to MBS rebates than to increases in the premiums they charge consumers.



[7] For example, 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

Figure 2: Why is there a gap? [8]



(a) Index comprising of average weekly earnings and Consumer Price Index (70:30) reflecting the average cost structures in medical practices.
(b) Index of Medicare fees as determined by the federal government.

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 when MBS rebates have not. This has contributed to a growing gap between MBS rebates and the actual costs of providing healthcare in Australia.

This is illustrated in Figure 2, which compares increases over time in:

(a) 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

(b) indexation of MBS rebates as determined by the federal government.

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]

[8] https://feeslist.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

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 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 the use of the revised indexation formula from 1 July 2024 will produce greater increases to Medicare rebates than has previously been the case.

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. This is when the doctor agrees with the insurer to charge the same amount the insurer has agreed to pay for that medical service. Patients do not incur an out-of-pocket cost for these medical services, and the agreed no gap fee is generally higher than the MBS rebate.

In the 2023–24 financial year, 87.7 per cent of medical services provided to privately insured patients in hospitals were provided by doctors at no gap rates.[10]

This represents a decline of 2.4 per cent on the 89.3 per cent of privately insured patients who received no gap medical services three years ago during the 2020–21 financial year.[11] It also reflects the choice of some doctors not to accept the no gap arrangements offered by some insurers because those doctors consider the amounts offered by those arrangements too low to cover their costs of providing the relevant medical service.

Known gap arrangement

Many, but not all, 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 greater than the known gap amount (which is usually $500).

In the 2023–24 financial year, 9.3 per cent of medical services provided to privately insured patients in hospitals were provided at insurers' known gap rates for the medical service.[12]

Following AMA advocacy, one of Australia's largest private health insurers, nib, has introduced known gap arrangements from 1 October 2024.[13]

[10] APRA annual private health insurance membership and benefits statistics 2023–24.
[11] APRA annual private health insurance membership and benefits statistics 2023–24.
[12] APRA annual private health insurance membership and benefits statistics 2023–24.
[13] https://www.ama.com.au/ama-rounds/9-august-2024/articles/nib-medigap-introduces-known-gap

No arrangement

It is important to note 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 3 below.

Figure 3: Private health insurer billing scenarios and out-of-pocket costs for a knee replacement.[14]

MBS 49518 Fee: $1,501.30; **MBS Benefit:** 75 per cent = $1,126.00

Situation	Doctor's fee	MBS Benefit	Insurance medical benefit	Out-of-pocket costs
Doctor accepts insurers no gap medical benefit amount	$2,470.25	$1,126.00	$1,344.25	$0.00
Doctor accepts insurers known gap arrangement	$2,836.80	$1,126.00	$1,210.80	$500.00
Doctor does not accept fee cap under insurer's no gap or known gap scheme	$3,200.00	$1,126.00	$375.33	$1,698.67

Using a knee replacement (MBS item 49518) as an example, Figure 3 demonstrates these three billing and payment scenarios, where the private health insurer has set a no gap medical benefit of $2470.25 (including the Medicare benefit), a known gap medical benefit (including the Medicare benefit) of $2336.80, and a maximum gap amount of $500.

[14] MBS Fee and benefit at 1 November 2024; insurer benefit taken from https://www.bupa.com.au/-/media/dotcom/files/for-provider/bupa-national-medical-no-gap-and-known-gap-schedule-1-november-2024.xlsx; (note that new rates were released on 1 January 2025, but we have used 2024 rates in line with the rest of statistics included in this report).

Insurance agreements with hospitals

The insurance benefits paid for hospital and even medical services depend not only on the type and tier 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 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.

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 privatehealth.gov.au website

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 the details relevant to your own or your family's situation. The privatehealth.gov.au website has information on what to look out for when changing your insurer.

The importance of checking whether your health fund has an agreement with your preferred hospital is illustrated by the latest contract dispute between Healthscope hospitals and numerous health funds. On 22 November 2024, Healthscope, one of the larger chains of private hospitals which operates across Australia, terminated contract agreements with BUPA, and health funds represented by the Australian Health Services Alliance (AHSA). Although Healthscope has now reached agreement with BUPA, at the time of writing, it seems that existing contract agreements between Healthscope and AHSA insurers will run out from 4th March 2025.[15]

Although the AMA has urged all parties to return to the negotiating table, it is not clear when this dispute will be resolved.[16]

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 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 and update a comprehensive resource that supports a collaboration between doctors and their patients to ensure fully informed financial consent.

The AMA Guide to Informed Financial Consent 2024 — assisting patients to understand their healthcare and its costs 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.

[15] AHSA member funds include ACA Health, AIA Health Insurance, Australian Unity, CBHS Corporate Health, CBHS Health Fund, Defence Health, Doctors Health Fund, Emergency Services Health, Frank Health Insurance, GMHBA, HBF Health, Health Care Insurance, Health Insurance Fund of Australia, Health Partners, Latrobe Health Services, Navy Health, Nurses and Midwives Health, Onemedifund, Peoplecare Health Insurance, Phoenix Health Fund, Police Health, Queensland Country Health Fund, Reserve Bank Health Society, see-u by HBF, Teachers Health Fund, Territory Health Fund, TUH, UniHealth Insurance, Union Health and Westfun.

[16] https://www.ama.com.au/media/ama-urges-healthscope-bupa-and-ahsa-resolve-funding-disputes

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. It 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

Over the past 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[17] to help Australians understand the cost of common medical procedures provided by specialist medical professionals.[18]

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.

The website shows general information on typical costs for common services provided by general practitioners (GPs) and non-GP specialists, both in and out of hospital, with more than 1,000 specialist treatments listed. The Department of Health and Aged Care has been working to enhance the website so more individual medical specialists will find it easy to add indicative fee estimates for common medical procedures and their arrangements with different private health insurers.

While this website 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 is therefore important to note 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 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 settings.

To ensure 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.[19]

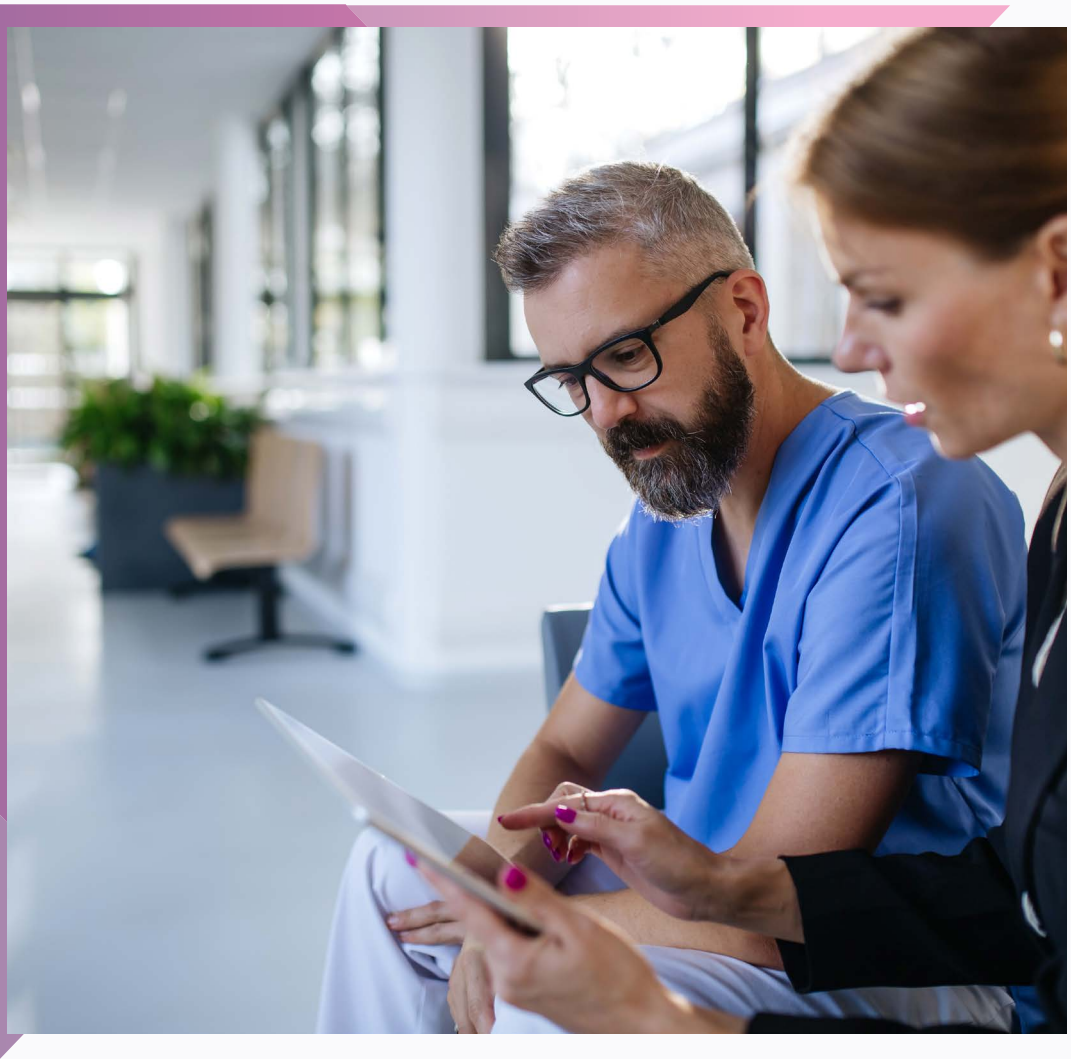
---

[17] https://www.health.gov.au/resources/apps-and-tools/medical-costs-finder#what-the-medical-costs-finder-is
[18] https://www.greghunt.com.au/new-website-to-improve-consumer-understanding-of-medical-costs/
[19] 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.

Consumers should also be aware the government's Medical Costs Finder website[20] does not include any information on how long you are likely to wait for planned surgery or an outpatient clinic appointment at your local public hospital — important information to have when considering your options. The AMA's 2024 Public Hospital Report Card provides information on average waiting times for planned surgery in each state and territory, which may be helpful.

The AMA is strongly committed to information sharing between doctors and patients to create agreed treatment plans and to ensure patients understand the 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 your financial consent to the procedure (or your decision to reconsider your options) is fully informed.

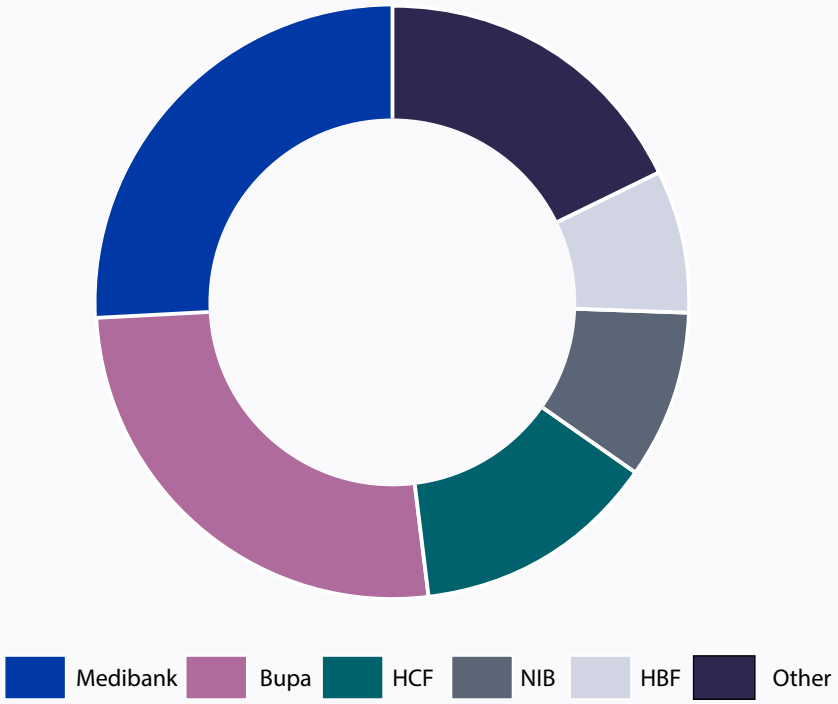
To that end, the AMA strongly recommends patients refer to its Informed Financial Consent Guide 2024 so they fully understand the financial issues relevant to their individual situation.



[20] https://www.health.gov.au/resources/apps-and-tools/medical-costs-finder#what-the-medical-costs-finder-is

What your premiums give back

Figure 4: Insurer market share, June 2024.



As shown in Figure 4, by June 2024, the five largest health insurers had increased their combined market share to 82.1 per cent, up 0.5 per cent on June 2023.[21] This market share gives the large insurers significant power when negotiating contracts with private hospitals and medical practitioners.

Benefits for hospital treatment paid by health insurers

There are two key measures of benefits insurers pay for medical treatment in hospital:

- 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.

[21] APRA annual private health insurance membership and benefits statistics 2023–24

Figure 5: Benefits paid for select admitted medical services by different private health insurers, 1 November 2024.[22]

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	$212.40	$243.05	$254.90	$257.00	$247.55	$239.20	$264.00	$24.80 10%
12203	Overnight Investigation for sleep apnoea	$669.85	$797.70	$797.10	$810.40	$812.25	$774.40	$830.30	$55.90 7%
13950	Cytotoxic Chemotherapy	$123.05	$148.85	$156.25	$145.20	$139.90	$135.30	$156.35	$21.05 16%
16519	Uncomplicated Delivery (of baby)	$790.60	$2,213.65	$2,276.95	$2,149.75	$1,766.95	$1,966.40	$2,254.30	$510.00 29%
16522	Complicated Delivery (of baby)	$1,856.15	$2,658.00	$2,654.30	$2,635.90	$2,619.55	$2,472.40	$2,881.05	$408.65 17%
18216	Epidural anaesthesia during labour	$216.35	$350.60	$350.50	$340.60	$337.05	$338.00	$344.05	$13.55 4%
30445	Cholecystectomy	$947.95	$1,353.15	$1,346.10	$1,349.30	$1,137.50	$1,312.00	$1,272.80	$215.65 19%
30648	Femoral or Inguinal Hernia	$529.25	$762.60	$751.55	$762.10	$715.30	$732.50	$713.80	$48.80 7%
30720	Appendicectomy	$507.45	$728.05	$720.60	$735.80	$685.85	$702.30	$684.50	$51.30 7%
31512	Breast, malignant tumour, removal	$740.65	$1,086.00	$1,051.70	$1011.85	$1001.05	$1025.10	$985.30	$100.70 10%
32139	Haemorrhoidectomy	$418.90	$594.80	$573.90	$596.20	$542.05	$552.90	$557.30	$54.15 10%
32222	Colonoscopy	$380.90	$528.55	$521.85	$506.60	$492.90	$502.80	$503.60	$35.65 7%
32500	Varicose Veins	$125.10	$193.20	$182.65	$195.60	$170.25	$182.50	$167.05	$28.55 17%
35657	Vaginal Hysterectomy	$768.70	$1,262.20	$1,245.30	$1,259.00	$1,158.80	$1,241.10	$1,349.75	$190.95 16%
37623	Vasectomy	$261.90	$403.20	$398.10	$424.30	$399.95	$407.10	$353.25	$71.05 20%
39331	Carpal Tunnel Release	$315.30	$541.70	$517.10	$528.25	$477.95	$504.80	$501.15	$63.75 13%
39710	Craniotomy	$2,760.80	$4,533.10	$4,527.70	$4,408.70	$4,185.60	$4,420.00	$4,389.55	$347.50 8%
41789	Tonsils or Tonsils and Adenoids	$336.85	$620.10	$619.80	$556.00	$505.20	$591.20	$567.75	$114.90 23%
42702	Cataract Surgery	$866.50	$1,388.30	$1,343.10	$1,348.65	$1,310.75	$1,361.30	$1,350.50	$77.55 6%
46340	Synovectomy of wrist	$451.45	$704.65	$699.75	$758.45	$680.50	$720.10	$654.50	$103.95 16%
49518	Knee Replacement	$1,501.30	$2,470.25	$2,372.05	$2,338.05	$2,306.10	$2,386.10	$2,346.90	$164.15 7%

Highest benefit paid — Lowest benefit paid

1	2	3	4	5	6	7	8

[22] Sources are MBS, BUPA no gap, HCF Medicover no gap, AHM/Medibank GapCover,NIB no gap, AHSA no gap (NSW), and HBF no gap (WA) rates from 1 November 2024. Note that insurer rates listed here include the applicable MBS benefit.

Private health insurers will generally aim to set policy 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 an insurer may agree to pay varies by insurer, policy, procedure and whether the treatment is planned or required thanks to an accident or other emergency. The privatehealth.gov.au website has information for consumers on how insurers deal with unplanned treatment and complications, and we recommend consumers read it.

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 as shown in Figure 5, different insurers can pay significantly different medical benefit amounts for the same procedure.

Figure 5 demonstrates the different medical 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 by the insurers listed in Figure 5, but it is important to note the table does not represent benefits paid by the entire industry.

Figure 5 also illustrates the significant variation between the amounts different insurers will pay for the same procedure. For example, for MBS Item 16519 (uncomplicated delivery of a baby), there is a 29 per cent variation ($510 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 these payments relate to the relevant MBS item and insurer description. For any specific procedure or service, such as a knee replacement or other surgery, additional MBS items may need to be billed by other doctors or health practitioners that provide necessary related services (for example, anaesthesia, pathology or diagnostic imagery).

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 provided for some insurers in Figure 5.

For example, the Australian Health Service Alliance benefit for cataract surgery (MBS Item 42702) in New South Wales is $1,361.30. However, if you are in South Australia, that benefit is $1,199.20.[23] This is a difference of $162.10 or 13.5 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 insurer with a greater percentage of no-gap services has a more effective rebate scheme in that state,

[23] AHSA South Australian Access Gap Cover Fee Schedule from 1 November 2024

and that consumers who hold hospital insurance policies with that insurer are less likely to have out-of-pocket costs after their medical service.

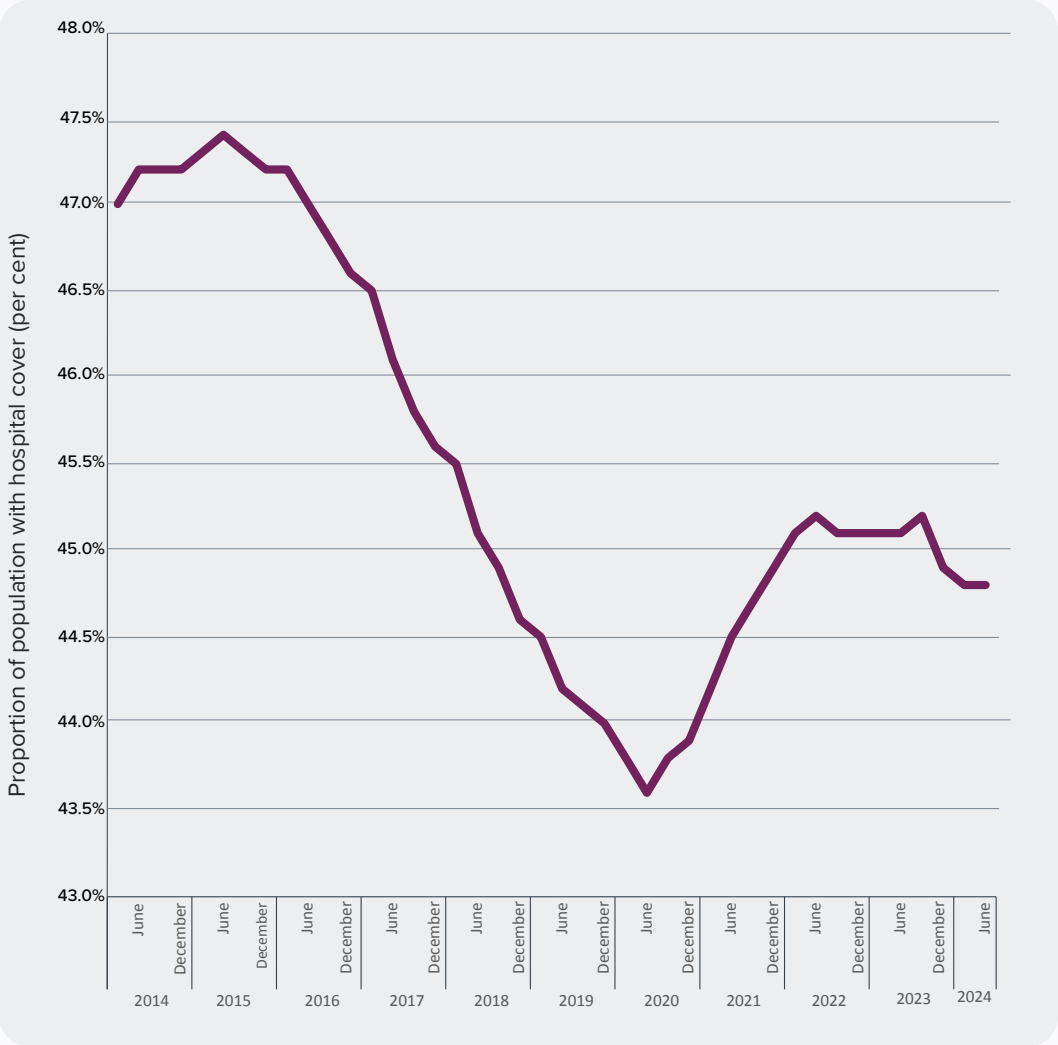
Overall, the best private health insurer for consumers may depend on where they live, so it is important to compare benefits and gap schemes of different insurers operating in your state or territory before selecting a private health insurance policy product.

Trends in private health insurance

Private health insurance performance

At the end of June 2024, 44.8 per cent of Australians had private hospital treatment insurance, which represents a drop of 0.3 per cent from the June 2023 figure of 45.1 per cent, and a drop of 2.6 per cent on the June 2014 figure of 47.4 per cent.

Figure 6: Proportion of population with PHI hospital treatment cover. [24]



Although Figure 6 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.

[24] APRA Statistics Quarterly private health insurance membership coverage June 2014 to June 2024.

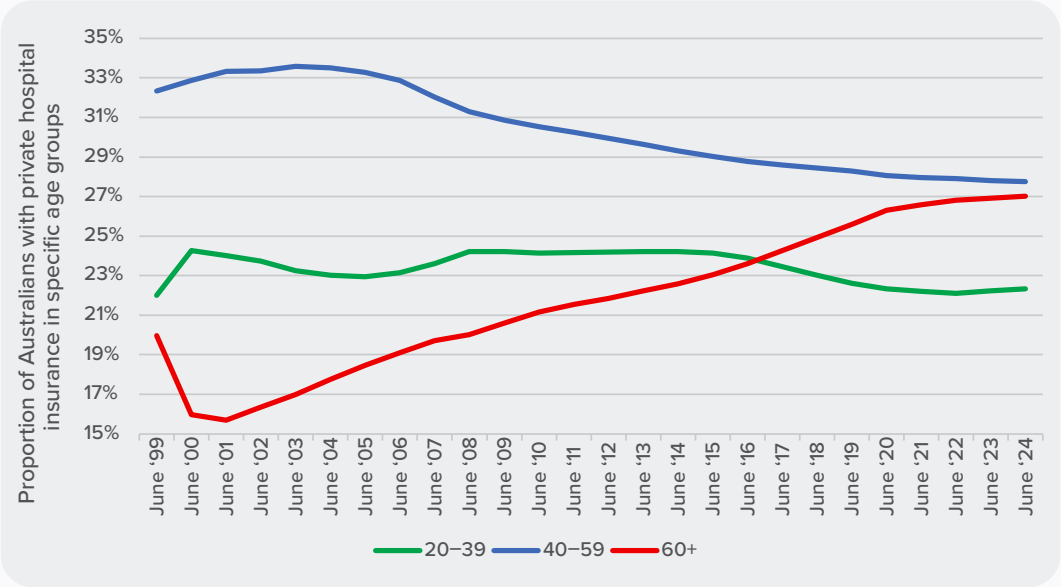
An increase in the proportion of people with hospital insurance who are from more senior age groups has consequences for policy premiums, because insurers pay out a lot more in benefits to these age group than they do for younger cohorts of insured people.

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-age people) insurers spread the costs by raising premiums for all age groups.

As shown in Figure 7, the rate of increase in the over 60 age group taking out private hospital insurance has slowed considerably in the past few years, as has the decline in the proportion of those in the 40–59 age group. The age group which recorded the biggest increase in private hospital insurance membership in the 2024 financial year was people aged 25–29, who recorded an increase in membership of 7 per cent, or 35,000.

Nevertheless, given an ageing population, it is likely the 60-plus age group will become the largest hospital-insured cohort in the foreseeable future.

Figure 7: **Demographics of the private hospital insured population, June 2009–June 2024.**[25]



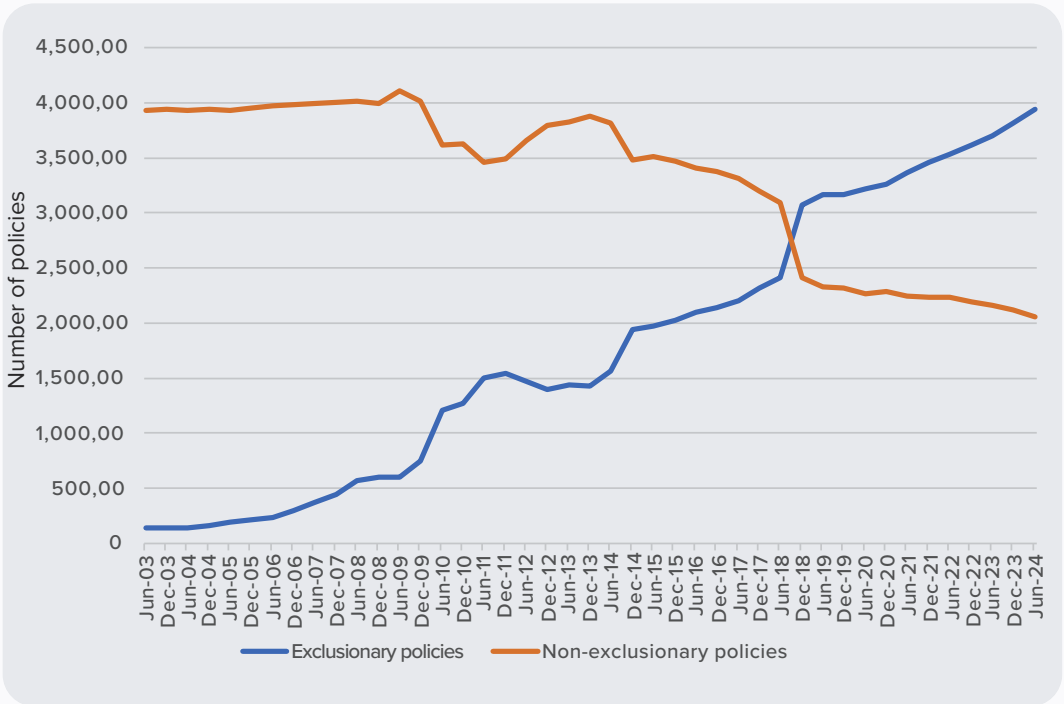
[25] APRA Statistics Private Health Insurance Membership Trends June 1999 to June 2024.

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.

Another useful measure for consumers to understand the value of private health insurance is examining whether their policy contains exclusions. Only 15 years ago, very few policies had exclusions, but in 2018, for the first time, most hospital insurance policies contained exclusions. As shown in Figure 8, the trend towards an increasing proportion of hospital insurance policies containing exclusions has continued its steady rise, with 65.8 per cent of Australians covered for private hospital treatment now covered under an exclusionary policy.[26]

Figure 8: Change in private health insurance hospital treatment[27] exclusionary and non-exclusionary policies, June 2003–June 2024.[28]



The trends shown in Figure 8 reflect changes in the tiers of hospital cover consumers are willing and able to pay for. The policy premiums that some insurers' charge for gold tier policies — the only tier of policy products that must provide no-wait hospital maternity and psychiatric care — have become so expensive

[26] APRA annual private health insurance membership and benefits statistics 2023–24
[27] Includes hospital treatment only and hospital/general treatment combined policies
[28] APRA Statistics. Private Health Insurance Membership and Benefits — Part 1 Policies and Insured Persons June 2003–June 2024.

many Australians with private health insurance have dropped them in favour of less expensive silver or bronze policies in recent years.

Overall, government data suggests that between the onset of the pandemic in 2020 and December 2023, and in the face of increased premiums competing with other cost of living pressures, close to 400,000 Australians downgraded to a lower tier of private health cover.[29]

Gold tier policy premium increases and 'phoenixing'

In December 2024, the Private Health Insurance Ombudsman (PHIO) released a statement on the fairness of insurer practices with respect to the pricing of gold tier hospital policy products. The statement reported the findings of an analysis undertaken by the Ombudsman into claims made in February 2024 by CHOICE magazine that some insurers were exploiting so-called loopholes in private health insurance regulations to increase the price of their gold tier policy products by more than 30 per cent. The PHIO largely substantiated CHOICE's claims and found some insurers had continued such practices even after CHOICE called them out in early 2024.

The practice of circumventing the premium round process by closing an existing policy product to new customers and then opening an almost identical policy product at a much higher price after the premium round process is over is known as 'phoenixing'. This is what some insurers have been doing to raise the price of some new policy products (most commonly gold policy products) above the increases approved for their existing policy products.

In his statement on these practices, the PHIO argued that although phoenixing is not strictly against the law, it is unfair to consumers and inhibits them from changing insurers or policy products for fear they will have to pay a higher price for a similar product if they do so. For this reason, the PHIO raised concerns about the practice of phoenixing with the Minister for Health and Aged Care and the department in August 2024.

On the same day the PHIO released its statement on phoenixing, Minister for Health and Aged Care Mark Butler publicly condemned the practice as 'price-gouging', saying it was contrary to the spirit and intention of the law, which is that the pricing of health insurance products is subject to the approval of the minister.[30] He added that his advice was that these practices are quite widespread. The minister has asked the Ombudsman to continue to monitor the extent of these practices, and has stated that if they continue, he will consider publicly naming the insurers involved, along with legislative options to outlaw the practice into the future.[31]

[29] Private health insurance reform data — 15 April 2024
[30] https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-press-conference-9-december-2024
[31] https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-press-conference-9-december-2024

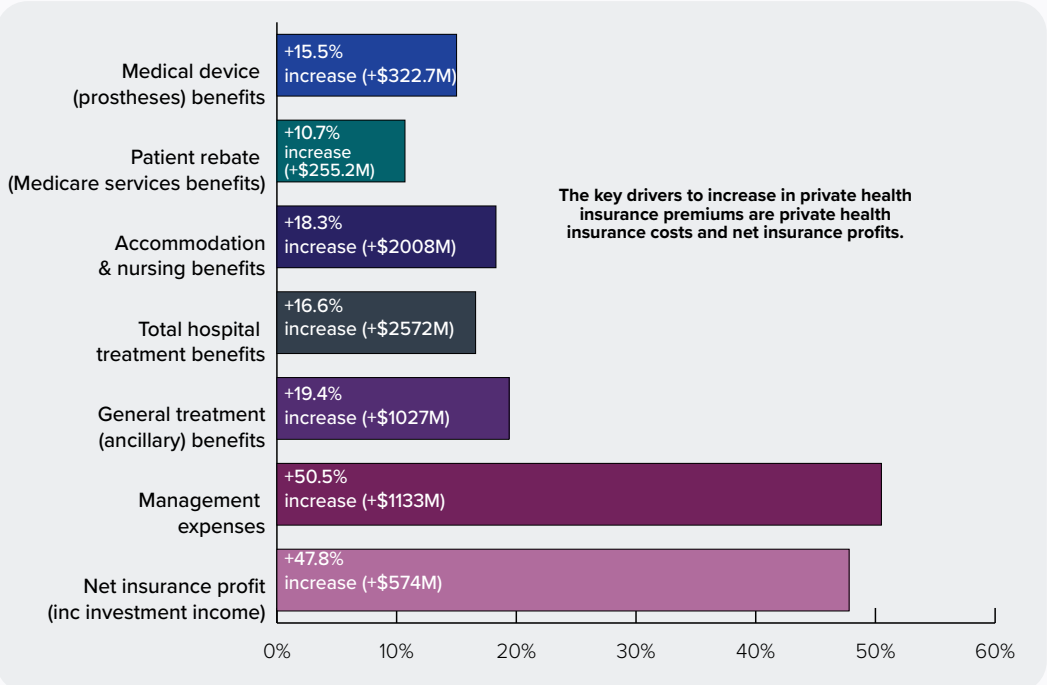
Private health insurer management expenses and profits

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 hospital treatment 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 9: How increased private health insurance premiums have been spent in the five years to June 2024.[32] [33]



All funds have management expenses, and depending on their position in the market, and their non-profit or for-profit status, they can have varying marketing costs, staff salaries, overheads like rent and claims handling expenses, and profit

[32] Notes: Year ending June 2019 has been used as the base year, as the most recent pandemic annual period. Re the 'net insurance profit' column, only net investment income attributed to private health insurance has been included, and tax paid is excluded, along with other revenue from health-related business and net investment income from other health-related business.
[33] Sources: APRA, 2023–24, 20241128 Quarterly Private Health Insurance Membership and Benefits September 2024.xlsx; For financial year 2019, the operating performance including operating profit: APRA 2019, PHI_operations_June2019.xlsx; For financial year 2023–24 premium revenue, claims, net margins, net investment income, management expenses: APRA, 2024, Quarterly private health insurance performance statistics database — September 2023 to June 2024.xlsx

margins that need to be built into these expenses. It is also important to note all insurers, including not-for-profits, must retain a small amount of profit to stay viable, under APRA's capital requirement rules.

However, as demonstrated in Figure 9, the key drivers to increases in private health insurance premiums over the past four years have been management expenses, and net insurance profits. These have risen much more sharply than benefits paid out for medical treatment in hospital, or general out-of-hospital treatment like dentistry or physiotherapy.

Private health insurer profits

Figure 9 demonstrates that whereas the amount paid out by private health insurers in hospital accommodation and nursing benefits has increased by 18.3 per cent over the past five years, net private health insurance profit (including net private health insurance investment income) has increased by a whopping 47.8 per cent over the same period.

APRA figures[34] show that in the 2024 financial year, the gross margin[35] Australian health insurers made from hospital insurance premiums alone amounted to $3.46 billion. This reflects a gross margin of 15.9 per cent of hospital premiums paid by consumers, meaning about 16 per cent of premiums paid were not returned to consumers in the form of benefits for treatment. Although this represents a significant improvement for consumer value-for-money on the same figure for the 2023 financial year (a $3.69 billion, or 18.4 per cent gross margin for hospital treatment insurance), it remains significantly worse than gross hospital insurance margins for the 2019 financial year, which were around 12 per cent.

The AMA continues to call for insurers to be required to return at least 90 per cent of private health insurance premiums paid back to consumers in the form of benefits for treatment.

Overall, the same APRA figures show that in the 2024 financial year, health benefits funds[36] operating in Australia made $2.226 billion dollars in pre-tax profits from continuing operations, in addition to making $980 million dollars from investments they hold. Taken alone, the same APRA figures show the top two for-profit health benefit funds in Australia by membership — Medibank and BUPA — collectively made a before-tax profit of $1.39 billion during the 2024 financial year.[37]

---

[34] APRA annual private health insurance statistics 2023–24**,** Power BI version, p.6.
[35] Calculated as the total dollar amount of hospital insurance policy premiums received by the whole Australian health insurance industry in 2023–24, minus the total amount of hospital treatment benefits they paid out during the year. Management expenses and profit are taken from this gross margin.
[36] Health benefits funds are defined under the Private Health Insurance Act 2007 as funds that operate a health insurance business and/or both a health insurance business and health-related businesses (which may include businesses that provide goods or services to manage or prevent injuries, diseases or conditions, and/or provide insurance to people living in Australia who are ineligible for Medicare, among other things). So, profit at a health benefits fund level includes profits from health insurance and any eligible health-related businesses operated by the private health insurer.
[37] APRA annual private health insurance statistics 2023–24, Power BI version, p.6.

Management expenses

Figure 9 shows that while insurers' payouts for hospital medical services have increased by 10.7 per cent over the past five years, the amount they spend on management expenses has increased by 50.5 per cent over the same period.

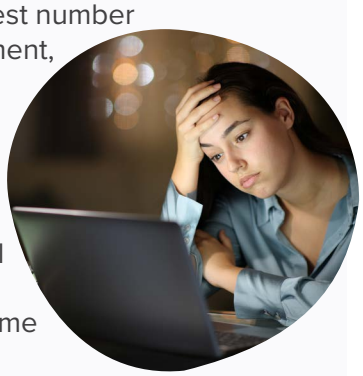
The amount paid by insurers for management expenses can vary considerably, with some insurers paying more than 15 per cent of their contribution income. However, the industry average for management expenses has been steadily increasing over many years. For example, for the 2023–2024 financial year, the industry average for management expenses was 11.46 per cent, compared to 10.8 per cent in the 2023 financial year, and 9.9 per cent in the 2022 financial year.[38]

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.

Complaints made about private health insurers

The office of 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. The PHIO provides information on complaints about insurers and how they are resolved, particularly through its quarterly and annual reports.

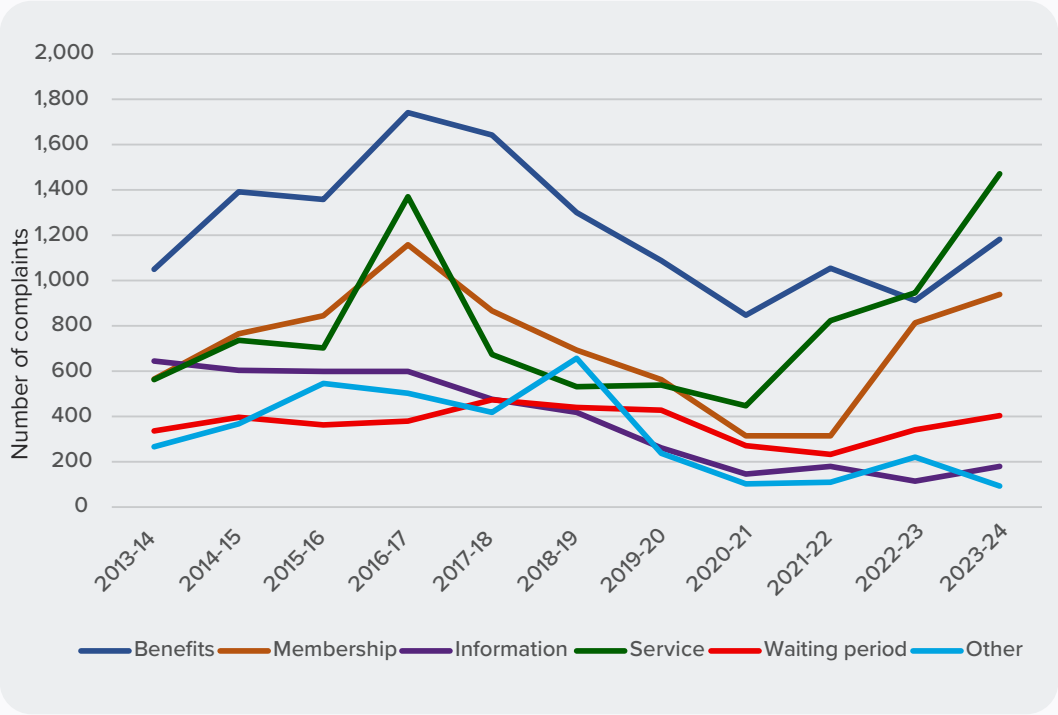
Complaint statistics published by the PHIO suggest that, despite fluctuations in total numbers, the greatest level of problems consumers experience continues to be across a small number of constant issues. In recent years, the highest number of complaints have centred on benefits (non-payment or delayed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



However, as reflected in Figure 10, during 2023–24, the PHIO handled 4,241 complaints, an increase of 23.7 per cent on the previous financial year. The PHIO noted this increase in complaints about benefits, service and membership was mostly attributable to the very large volume of complaints received in relation to Defence Health following a major computer system upgrade. This resulted in many complaints about delays on the phone, or in receiving written advice in response to a query, delays in benefit payments, premium payment problems, and later in the year, complaints about the cancellation of policies.

[38] APRA. Annual private health insurance statistics 2021–22, 2022–23, 2023–24.

Figure 10: Complaints made to the PHIO, by issue, 2013–14 to 2023–24.[39]



The PHIO has noted that this isn't the first time an insurer undertaking a major information technology system upgrade has received related complaints for many months afterwards. However, the Ombudsman also noted it took Defence Health much longer than expected to resolve these complaints and return to normal. In response, the PHIO has published an issues paper for insurers on best practice when undertaking a major system upgrade so disruptions and delays for policy holders can be avoided as far as possible.

The PHIO suggests insurers must do better at anticipating and planning for unexpected events, having well established centralised complaint handling processes, having enough well-trained and experienced complaints handling staff to deal with customer service problems, providing advance notice of the system change to customers, and monitoring the impacts of the change.

During the year, the Ombudsman also had to deal with a number of complaints in relation to what it called 'unreasonable' insurer refusal to pay benefits for Type C procedures where a medical practitioner had certified that the procedure needed to be conducted in hospital.[40] As a result, in February 2024, the PHIO published another issues paper, titled Can private health insurers decide that a patient does not need treatment in hospital?, which contained best practice guidance for private health insurers on this issue.

[39] Private Health Insurance Ombudsman State of the Health Funds Reports, Private Health Insurance Ombudsman State of the Health Funds Reports; Private Health Insurance Ombudsman Quarterly Bulletins.
[40] Type C procedures normally take place out of hospital (e.g. in a doctor's rooms or a clinic) unless the treating medical practitioner certifies that thanks to particularities of the patient's health status, it is safer to conduct them in hospital. In that event, a health insurer must pay benefits in accordance with the Private Health Insurance (Benefit Requirements) Rules.

The AMA recommends consumers with queries about their private health insurance speak to their insurer in the first instance. Like the PHIO, 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.

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 position statement 2024
- Informed Financial Consent position statement 2024
- AMA Guide to Informed Financial Consent 2024 — assisting patients to understand their health care and its costs
- AMA guide for patients on how the healthcare 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
- 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.

List of figures