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SUBMISSION

Monday, 30 March 2026

Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026

Submission to Senate Community Affairs Legislation Committee

By email: community.affairs.sen@aph.gov.au

Introduction

The Australian Medical Association (AMA) appreciates the opportunity to contribute to this Senate Community Affairs Legislation Committee (the committee) inquiry into the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026* (the Bill).

The Bill seeks to do two things:

1) it addresses the practice of product phoenixing by private health insurers that has become increasingly common and is driving up premium costs for patients, particularly for gold-level cover
2) it also provides a legislative basis for changes to the Medical Cost Finder (MCF) website intended to improve fee transparency.

The AMA supports the intent of the Bill, but in relation to the MCF website has serious concerns with several aspects of the Bill outlined in this submission. The AMA also believes provisions dealing with product phoenixing could be improved, also outlined below.

The AMA has strongly supported fee transparency to assist consumers and continues to do so. We do, however, hold significant concerns about the Department of Health, Disability and Ageing's (the department) proposal to publish a single annual "average fee" for each medical practitioner. The AMA is not convinced a single figure will deliver meaningful or fair transparency for consumers, given the diversity of clinical practice. This is because:

- average fees may be misleading
- certain practitioners may be disadvantaged

- insurer–hospital agreement dynamics sometimes drive out-of-pocket costs
- supervised services may skew a supervising practitioner's published average fee.

The AMA is particularly concerned the department has not consulted the medical profession on the scope of information that can be published on the website including the methodology underpinning the single fee, despite the clear risk of unintended, misleading, or harmful consequences.

It also considers existing safeguards inadequate: the Bill does not establish a clear, timely, and accessible review or complaints mechanism, relying instead on limited internal review and costly judicial review options unlikely to protect practitioners from reputational or financial harm once incorrect information is published.

The AMA commends the Bill for the inclusion of private health insurer fees and MBS rebates in the MCF website, as we have long argued true transparency for consumers requires publication of complementary information, including insurer-specific rebates, not just practitioner fees. To date, insurers have been very reluctant to publish this information on the existing MCF site.

History of AMA fee transparency support

The AMA has contributed to the development of the department's existing MCF website intended to provide consumers and general practitioners (GPs) with more detailed information about the costs of medical services and individual non-GP specialist fees. We have disseminated information about the website to our members and encouraged them to upload their fees to the website in regular member communications, and in 2024, our then President, Professor Steve Robson, uploaded his own fees as an example.

The AMA has also encouraged its members to upload its fees to the MCF website through relevant AMA documents, including:

- the AMA position statement on Setting Medical Fees and Billing Practices 2024
- the AMA position statement on Informed Financial Consent 2024
- the AMA Guide to Informed Financial Consent October 2024, which is co-signed by 28 medical colleges and societies.

The AMA's position statement on Setting Medical Fees and Billing Practices 2024 makes clear the AMA's view that:

- medical practitioners are free to place their own value on their professional skills and expertise and determine what they consider to be a fair and reasonable fee (taking their practice costs into account) for the services they provide in each individual case
- members should have a billing policy that is made available to patients
- the AMA does not support egregious charges — fees that the majority of a practitioner's peers would consider to be unacceptable
- all professional medical services provided should be billed, itemised and described with the applicable MBS item or the AMA Fees List item, for relevant services where there is no corresponding MBS item

- indexation of the MBS and the private schedules have not kept pace with the costs of providing medical care. This is why patients may have out-of-pocket costs for medical services. The AMA Fees List[1] is indexed annually considering the cost of providing medical services and is therefore higher than the MBS and private schedules
- the AMA opposes the introduction of any legislation that prescribes or restricts the fees medical practitioners must charge
- the AMA encourages good informed financial consent (IFC) and encourages medical practitioners to publish any indicative fees and gap arrangements for select high volume services on the MCF website, noting this website makes it clear any information provided is a guide only, and not a substitute for a medical quote or IFC.

Schedule 1: Transparency by default and information sharing

The review process

A fundamental flaw in the Bill is the absence of an effective, timely, and accessible mechanism for medical practitioners to correct inaccurate or misleading information once it is published. As acknowledged in the Explanatory Memorandum, the Bill does not establish any legislated review or complaints process; instead, practitioners are limited to an internal review by a ministerial delegate or to judicial review under common law.

The AMA rejects the proposition this provides adequate protection, particularly where published information — such as a single "average" fee — may materially affect a practitioner's reputation, patient volumes, and financial viability. An internal review process that offers only a yes-or-no decision, with no clear timeframe or merits-based assessment, is insufficient to address errors before harm occurs.

The AMA disputes the view that information published is all 'non-sensitive' and mostly already published and is therefore unlikely to harm the careers and incomes of affected medical practitioners.

Judicial review is also an unrealistic safeguard for most practitioners. Judicial review is costly, complex, and time-consuming, and therefore effectively inaccessible to individual doctors and small practices. Even where pursued, judicial review would not provide a prompt remedy capable of preventing or reversing reputational or financial damage caused by the publication of incorrect or misleading information.

[1] The AMA publishes the List of Medical Services (Fees List) which is available for free to members (and to subscribers through a paid licence). The Fees List is updated regularly to reflect changes to the Medicare Benefits Schedule and clinical practice, and the costs of providing medical services, as appropriate. This Fees List provides costing assistance and guidance only, and does not compel health practitioners to charge the fee set by the list, but does help AMA members ascertain further information about the procedures on the list.

Compounding this concern, the Bill explicitly limits the department's civil liability for harm arising from publication, while failing to provide practitioners with a proportionate counterbalance in the form of an independent, fast, and transparent correction mechanism. The AMA considers this imbalance inconsistent with principles of natural justice and regulatory fairness, particularly given the acknowledged likelihood that published information may influence patient choice and market behaviour.

The AMA recommends the Bill be amended to include a robust, fair and transparent review process to ensure practitioners can correct incorrect information on the website in a timely way.

The 'single fee' and the need for consultation

Given its strong support for fee transparency, the AMA retains concerns about the department's "analytical approach for the derivation of a single fee that can be published for a medical practitioner's provision of a service for a given financial year".[i]

Firstly, the 'single fee' may not provide helpful transparency to consumers. Secondly, the proposal, as articulated, may be unfair to many doctors. The AMA's concerns can be summarised as follows:

1) Many private specialists provide discounts to some patients on account of their age (e.g. children) or financial circumstances, but not to others, so an average fee (particularly an average based on previous year's data) may be misleading.

   Some non-GP specialists develop a well-deserved reputation for treating more complex patients and thus receive more referrals in relation to these more complex patients. Given the complexity of the cases they deal with, and related additional length of any procedures, their fees may be higher than those of other non-GP specialists. It is unclear how such individual circumstances could be accounted for in a single fee.

2) The Explanatory Memorandum considers the risks (to both practitioners and the department) of publishing this single figure, but it does not consider the reputational and viability risks to doctors (and potential legal claims) that may arise from non-publication.

   a. For example, relatively new doctors, or those who only perform a few procedures a year are unlikely to be included on the MCF website in order to protect the privacy of patient data. Given this, such doctors are likely to miss out on patients because they are not listed on the website.

3) The examples provided in figures 3 and 4 of the Explanatory Memorandum suggest the single fee figure will be per hospital, but it not clear if this will broken down by insurer for each hospital. Many doctors will have a "no gap" or "known gap" agreement with a private health insurer, but some insurers will not honour this agreement if the insurer does not also have a Hospital Purchaser/Provider Agreement (HPPA) with the hospital where the patient is being treated.

   In the case of Figure 3, for example, how would the MCF website clarify for the patient that the out-of-pocket costs they have to pay at Hospital B are insurer driven, rather than doctor driven?

4) Under subsections 324-5(9) and (10), the Bill provides that, for certain services specified in subsection 3(18) of the *Health Insurance Act 1973*, practitioners will be treated as having provided a service performed by a supervised person where the practitioner is present during the service. How will that affect the single average fee of the supervising practitioner?

The AMA has not been consulted by the department on the creation of a methodology for deriving a single annual fee figure it proposes. Given the concerns raised the AMA believes the department must establish robust governance arrangements that include the medical profession and other affected groups like private hospitals before going ahead with its proposals under this legislation.

Robust governance arrangements that include strong medical representation will be required both to reassure stakeholders as to the accuracy of the 'single fee', and to ensure there are appropriate recourse options and no unintended consequences, both for stakeholders and the department.

The AMA recommends the Bill should be amended to require the department to establish robust governance arrangements that include all affected stakeholders to:

- **ensure the accuracy of 'the single fee' the department proposes to upload to the MCF website**
- **avoid any unintended, unfair, or misleading consequences.**

Other information to be included on the Medical Costs Finder website

The AMA has serious concerns about proposed section 124ZY, which provides the Secretary with broad discretion to publish additional information on the MCF relating to medical practitioners, hospitals, and private health insurers. While the AMA supports transparency genuinely assisting consumers to understand healthcare costs and affordability, section 124ZY lacks clear legislative limits on the type, source, and purpose of information that may be published.

In its current form, the provision risks enabling selective or unbalanced transparency, where information is published without sufficient context, accuracy safeguards, or regard to the potential professional, reputational, and financial consequences for affected practitioners.

These concerns are heightened by the imbalance of risk embedded in the Bill. The Secretary is explicitly protected from civil liability arising from the publication of information under section 124ZY, while medical practitioners have no equivalent statutory protection and no guaranteed right to correct or challenge inaccurate or misleading information before harm occurs. The Explanatory Memorandum suggests the information to be published is "defined, limited and non-sensitive", yet also acknowledges it may influence consumer decision-making and practitioner demand.

The AMA strongly disputes the characterisation of practitioner-level fee or practice data as non-sensitive, particularly when it is distilled into simplified metrics that may not reflect clinical complexity, discounting practices, or insurer-driven cost settings. In the absence of a clear, timely, and independent review or correction mechanism, section 124ZY exposes practitioners to disproportionate risk without adequate procedural fairness.

The AMA is also concerned that the breadth of section 124ZY creates a real risk of future function creep, including the potential use or linking of external regulatory data, such as information held by

Ahpra or outcomes data. Given the focus of the website is on fee transparency, we think this represents a significant risk and could lead to perverse outcomes.

Ahpra data is collected for regulatory and patient-safety purposes, not for consumer cost comparison tools. Linking or repurposing such data in the MCF would risk conflating regulatory oversight with pricing transparency, and may lead consumers to draw inappropriate conclusions about practitioner quality, risk, or value, without the natural justice protections that apply in regulatory contexts. The release of outcomes data can also influence patient selection by practitioners and make it harder for patients with more complex needs to access the care they require.

This risk is particularly acute where historic or resolved regulatory matters — including matters that may have been settled or resolved without formal findings — could be republished in a consumer-facing context without independent review, proportionality, or a clear avenue for appeal, potentially causing serious and unjustified harm to practitioners' reputations and livelihoods.

The AMA's long-standing position is that transparency must be comprehensive, contextualised, and system-wide to be meaningful. Publishing practitioner fee information in isolation, or alongside selectively chosen insurer or hospital data, risks misleading consumers about the true drivers of out-of-pocket costs and undermining confidence in the MCF website as an impartial tool. If section 124ZY is to be retained, it must be amended to include clear statutory limits on the information that may be published, require balanced disclosure across all system participants (including insurer rebates and product design), and establish a prompt, independent mechanism for practitioners to seek correction of inaccurate or misleading information before reputational or financial harm occurs.

The AMA is concerned poorly designed transparency measures risk compounding existing pressures on practitioner wellbeing. Publishing simplified or potentially misleading information without adequate context, consultation, or timely avenues for correction may expose doctors to reputational harm, patient complaints, and financial uncertainty, all of which contribute to stress and burnout. At a time when the medical workforce is already under significant strain, policy settings must avoid creating punitive or adversarial environments for clinicians and instead support fair, proportionate, and system-wide approaches that recognise the realities of clinical practice and protect the wellbeing of those delivering care.

The AMA considers it essential the Bill be amended to explicitly limit the sources of information that may be published under section 124ZY and clearly prohibit the use or linking of Ahpra regulatory data unless there is a compelling, clearly defined public interest case, full consultation with the medical profession, and strong procedural safeguards.

Information about private health insurer premiums and rebates

As noted, the AMA supports fee transparency and welcomes the intent of the MCF website as a tool to assist consumers. The AMA has consistently emphasised to the department that true transparency will only be achieved if the information published provides a complete and accurate picture of the factors driving patients' out-of-pocket costs.

While the Bill enables the publication of additional information, including private health insurer rebates, we believe this should be done in parallel with any other information published on the

website, and not in tranches where medical practitioner fees are uploaded first and private health insurance rebates are added at an undefined later date.

Publishing medical practitioner fees in isolation risks misleading consumers by obscuring the significant role played by private health insurer benefit levels, product design, and contractual arrangements in determining what a patient ultimately pays.

Without clear, procedure-specific private health insurer rebate information — alongside Medicare rebates and indicative practitioner fees — consumers are unable to meaningfully compare policies or assess value for money, and responsibility for affordability pressures is unfairly shifted onto clinicians. Meaningful transparency therefore requires a system-wide approach, including the comprehensive publication of insurer rebates and premiums, to ensure patients understand the real drivers of out-of-pocket costs and can make informed choices about both their care and their private health insurance.

The AMA recommends the department be compelled to ensure the inclusion of private health insurer rebates are published in parallel to other information on the MCF website, and not at a later stage.

Schedule 2: Regulating premiums

The AMA has long advocated for closing the legislative loophole allowing private health insurers to 'phoenix' products:

- as outlined in the AMA's June 2024 submission to the department's consultation on the annual premium round process
- in our 2024 Private Health Insurance Report Card, and subsequent report cards
- in the AMA submission on phoenixing in October 2025.

In the latter, the AMA broadly supported the department's suggested approach, noting it also agreed private health insurers should retain the ability to close or terminate products to manage prudential risk, while being prevented from using such product closures to facilitate phoenixing.

However, the AMA's support came with several caveats with respect to the need for legislated definitions of the terms 'public interest' and 'exceptional circumstances', neither of which are currently defined in the *Private Health insurance Act 2007*. Neither of these concerns are appropriately addressed in the subject Bill.

In its submission, the AMA also noted the consultation paper made no mention of penalties that would be applied to private health insurers who continued the practice of product phoenixing once legislative changes to outlaw the practice were made.

Proposed amendments to address phoenixing

The AMA the Bill taking a broad view of product phoenixing — one that recognises insurers can reduce the value of private health insurance to consumers not only by closing a product and opening one with the same benefits at a higher price, but also by reducing policy benefits, or increasing excesses or copayments.

We also support the Bill requiring private health insurers to apply to the Minister for approval to set premiums for all products, including premiums of products where the value or cover provided by those products has reduced.

However, rather than limiting applications outside the annual premium round to genuinely exceptional circumstances, the Bill effectively permits private health insurers to submit product and premium changes at any time.

The Bill provides only a minimal and largely illusory disincentive for private health insurers to submit applications for new products or premium changes outside the normal annual premium round. That disincentive rests solely on a technical distinction between the public interest test applied to applications made during the approved application period and the test applied to applications made outside that period.

Under proposed subsection 66-8(5), consistent with the existing Act, the Minister may approve applications submitted during the approved application period provided they are *not contrary to the public interest*. By contrast, proposed subsection 66-8(6) requires the Minister to approve applications submitted outside the approved period only if satisfied that approval *is in the public interest*. However, neither "in the public interest" nor "not contrary to the public interest" is defined in the Bill or in the Private Health Insurance Act 2007. While the Explanatory Memorandum suggests the former represents a more stringent test, the absence of any legislative definition or clear distinction between the two standards renders this difference largely semantic.

In practice, without clear statutory guidance, the purportedly "more stringent" public interest test risks functioning as a superficial constraint rather than a meaningful deterrent to out-of-cycle applications.

The AMA is concerned this will materially impact on efforts to restrict the behaviour the Bill is intended to address, including product phoenixing. The absence of a clearly defined public interest test also leaves excessive scope for inconsistent ministerial decision-making over time. If applications outside the approved application period are to be genuinely exceptional and justified, the Bill must include a clear, legislated definition of the public interest to guide both insurers and the Minister.

The AMA recommends the committee amend the Bill to include a clear, legislated definition of the "public interest" test to be applied to all private health insurer applications for product and premium changes, whether submitted during or outside the approved application period. This definition should

- **establish a genuinely higher threshold for out-of-cycle applications**
- **ensure such applications are exceptional and justified**
- **constrain ministerial discretion to promote consistency, transparency, and accountability.**

Without a clearly defined public interest test, the Bill risks failing to meaningfully deter product phoenixing and undermines its stated policy intent.

No penalties for non-compliance

Finally, the AMA notes with concern the Bill makes no mention of any penalties that could be applied to private health insurers who continue the practice of product phoenixing once these legislative changes are implemented. Given the extraordinary financial resources and profitability of the largest insurers that hold more than 80 per cent share of the private health insurance market in Australia, along with the failure of some to change their behaviour even after a warning from the Minister last year, the AMA believes penalties should be introduced for non-compliance. These penalties should be sufficiently severe to act as an effective deterrent against flouting the law.

Such penalties could include the insurer being publicly named by the Minister to alert consumers, as well as the imposition of financial penalties of a magnitude that would make it unprofitable for insurers to flout the law in the first place.

The AMA recommends the Bill should be amended to include civil penalties for private health insurer non-compliance with the prohibitions on product and premium 'phoenixing', with penalties sufficiently severe to act as an effective deterrent to this behaviour.

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[i] Explanatory Memorandum, p.39