AMA

PRIVATE HEALTH INSURANCE REPORT CARD 2019

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INTRODUCTION

The unique balance between the public and private sectors makes the Australian health system one of the best in the world. But we are at a precipice.

Increases in premiums are averaging 3 to 5 per cent a year, while wages growth is firmly stuck at around 2 per cent. One of the reasons premiums are going up is because an ever-increasing number of younger and healthy Australians are opting out of private health insurance.

This is leaving a higher proportion of older patients who are increasingly more likely to be suffering from illness or chronic disease and who are expensive-to-insure patients in the system. More of these patients are joining every day. This causes fund outlays to go up, putting even more pressure on premiums.

Australians need a private health insurance system that offers affordable, transparent, and appropriate cover. The Government must ensure that the private health sector remains efficient, robust, and productive. The Government must build on the reforms of 2018, and start to address indexation and variation in rebates and insurer contracts. We need to work to bring back the value in insurance policies, before it is too late.

Private health insurance – a changing landscape

In October 2018, the Commonwealth Government finalised new rules governing private health insurance. The new rules established a more transparent and easier-to-understand system of clinical categories and tiers of insurance product – Gold, Silver, Bronze, and Basic.

The aim of these reforms was to deliver a system that provides clearer information to consumers and allows them to compare different health insurance policies and choose the cover that best suits their needs.

In addition to the Gold, Silver, Bronze, and Basic classification, the Government announced a range of other reforms including:

- A premium discount of up to 10 per cent for young Australians aged 18 to 29 – which they will be able to keep until they turn 40.
- Greater access to mental health services by allowing people to upgrade their coverage and avoid a waiting period.
- Australians living in rural and remote areas are now able to receive travel and accommodation benefits as part of hospital treatment cover. This will help those who can't access treatment locally.
- Increased support for the Private Health Insurance Ombudsman.

New insurance policies began to be categorised under this system from 1 April 2019[1], and by April 2020 all products must fully comply with the new arrangements. These are the biggest changes to private health insurance in many years – so this Report Card contains a new section providing more detail about these reforms and how they will impact on individuals.

Private health insurance under pressure

Private health insurance coverage (hospital treatment products) is falling. We have now seen four years of decreasing hospital treatment coverage as a percentage of the population, from 47.4 per cent in the June quarter of 2015, to 44.2 per cent as of June 2019[2].

In the same period, the number of people holding private hospital coverage (with hospital treatment products) fell from 11,276,328 to 11,227,569 – a difference of 48,759[3].

1 The implementation of the changes to private health insurance on 1 April 2019 is the reason the AMA delayed the publication of the 2019 Report Card.

2 APRA Private Health Insurance Quarterly Statistics June 2019 PDF

3 APRA Private Health Insurance Membership Trends June 2019 XLSX

However, this decline is not even. Younger cohorts are dropping their insurance, leaving a higher concentration of older, high-claiming members. The number of people covered by private health insurance has declined in every age group up to age 60, with the biggest fall in the 20-39 year-olds.

Meanwhile, the number of people with private health insurance is rising for every age group over 60, particularly among 70-79 year-olds. There are almost 100,000 fewer 20-39 year-olds and 360,000 more people over 60 insured now than five years ago[4]. As the insured population continues to age, the likelihood of requiring hospital treatment rises. This generates higher claims and exerts upward pressure on premiums, exacerbating this issue further.

The AMA Private Health Insurance Report Card 2019

This is the fourth in the AMA's annual series of Report Cards on private health insurance. It is designed to assist patients/consumers by highlighting the differences in private health insurance policies, the operations of funds, and the changes implemented by the Government.

The Report Card provides consumers with indicators to help choose the right cover, noting that what is important in a health insurance product differs for each individual or family[5].

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

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

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

Dr Tony Bartone
President
October 2019

4 Australian Financial Review - Private health cover is in a death spiral (accessed 4 September 2019)

5 The information in the tables in this report is current as at 30 September 2019 and is based on a detailed review of the policies offered by private health insurers, benefit schedules published by private health insurers, and information reported annually by the Private Health Insurance Ombudsman at www.phio.gov.au and the Australian Prudential Regulation Authority at www.apra.gov.au. These reports are updated throughout the year and the date of the publication is noted in the citation.

PRIVATE HEALTH INSURANCE IN AUSTRALIA

How health care is funded

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

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

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

Commonwealth, State, and Territory Governments fund public hospitals, which provide free admitted services to public patients.

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

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

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

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

Premiums

A 'premium' is the amount consumers pay for a contract of their insurance. Premiums are an income source for insurers, which helps pay for their business costs. 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. The Commonwealth Government must approve the rate before it comes into effect.

Cover

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

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

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

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

Out-of-pocket costs

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

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

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

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

By law, private health insurers must top up the Medicare payment by at least 25 per cent of the relevant MBS fee. Insurers can pay a higher level of benefit than this in particular circumstances. These circumstances are explained under the heading 'no gap and known gap' on page 6.

Medicare freeze and PHI rebate rises

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

Generally, Medicare pays:

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

The MBS was not designed to cover the full cost of medical services. MBS items were not indexed (increased) for a number of years.

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

Under an indexing process, the MBS rebates are raised according to the Department of Finance'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[6].

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

Medical fees need to cover income, staff wages, medical indemnity insurance, and practice costs (including rent, medical supplies, equipment). All these costs have risen year on year, even if rebates haven't. This has contributed to a growing gap between the MBS rebate and the actual costs of providing health care in Australia, as shown in Table 1.

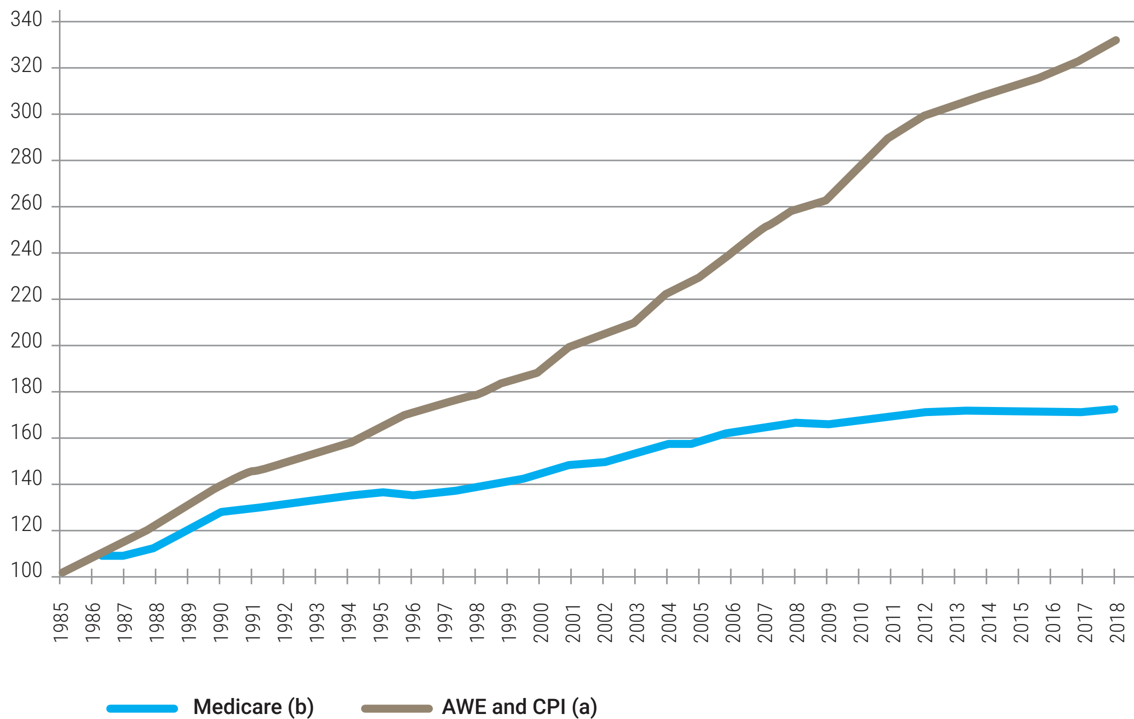

Table 1: Economic indices from 1986.

(a) Index comprising of Average Weekly Earnings and Consumer Price Index (70:30).

(b) Index of Medicare rebates as determined by the Commonwealth Government.

6 In the five years from 2015-2019, CPI rose 8.1 per cent, CPI for health alone rose 19 per cent but the MBS index only rose 1.6 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

No gap and known gap arrangements

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

No gap arrangement

Most private health insurers offer 'no gap' arrangements, when the doctor agrees with the insurer to charge the exact same amount that the insurer has agreed to pay for that medical service. In many cases, doctors provide the service at 'no gap'[7] 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 fee.

Known gap arrangement

Many insurers will pay a benefit that includes a 'known gap'. This is where the insurer will allow the doctor to charge a fee that is a set amount above the insurer's total benefit amount (often a maximum of $400 – $500 above the agreed fee). The patient pays an out-of-pocket amount at the 'known gap' rate for the medical service.

No arrangement

When there is no arrangement between a doctor and an insurer, or the doctor charges more than the gap scheme amount, 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. This is because the insurer in this situation will only pay the minimum benefit amount required – 25 per cent of the MBS fee.

Lower benefits paid by the insurer mean higher out-of-pocket costs for patients. 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 (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 Table 2 on page 7.

Using total hip replacement (MBS item 49318) as an example, Table 2 demonstrates the three billing and payment scenarios, where the private health insurer has set a medical benefit of $2,142.20 and a 'known gap' amount of $500.00.

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7 https://www.apra.gov.au/sites/default/files/quarterly_private_health_insurance_statistics_june_2019.pdf

Table 2: Private health insurer billing scenarios and out-of-pocket costs for a total hip replacement

MBS 49318 Fee: $1,338.90 **Benefit:** 75% = $1,004.20

	Doctor's fee	MBS Benefit	PHI medical benefit	Out-of-pocket costs
Doctor accepts PHI medical benefit amount	$2,142.20	$1,004.20	$1,138.00	$0.00
Doctor accepts PHI known gap arrangement	$2,642.20	$1,004.20	$1,138.00	$500.00
The benefit amount does not cover the doctor's fees	$2,650.00	$1,004.20	$334.70	$1,311.10

Excesses and co-payments for hospital admissions

Most health funds will offer you the option of nominating an 'excess' or 'co-payment' on your hospital policy in return for reduced membership 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.

Agreement hospitals

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

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

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

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

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

To find out which private hospitals near you have agreements with your health insurance fund, you can contact your insurer or use the tool provided at:

https://privatehealth.gov.au/dynamic/agreementhospitals/fund/aca

Private health insurer contracts

As the financial position for health insurers becomes tighter, they are looking for ways to reduce their costs. Some insurers are looking at ways they can improve the health of their customers, thereby reducing their hospital usage. Other insurers are looking at providing health care more flexibly by offering some services through 'hospital in the home' type programs.

In 1995, only 4 per cent of the 49 insurers operated on a for-profit basis. By 2017, almost 70 per cent of the 37 insurers were for-profit operators. With this increased number of for-profit insurers, and with the largest for-profit providers having a significant market share each, this is leading to increased use of selective contracting by health insurers. This enables insurers to influence, even dictate, the health care pathways available to their customers who are trying to reduce their out-of-pocket gaps.

Last year, Bupa announced that its members can only access a no gap or known gap arrangement with a doctor if that service is provided in a Bupa agreement private hospital – even if the doctor is happy to bill at the no gap rate at an uncontracted private hospital. This adds an extra layer of complexity for customers trying to negotiate an already highly complex environment. To avoid or minimise their costs for many procedures, patients have to find a gap cover doctor, a gap cover anaesthetist, and a contracted facility.

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INFORMED FINANCIAL CONSENT

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

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

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

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

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

The Informed Financial Consent (IFC) guide includes:

- an Informed Financial Consent Form for doctors and patients to use together;
- information on fees and medical gaps; and
- questions for patients to ask their doctors about costs[8].

Publishing Doctors' Fees

Throughout the last two years, the publication of doctors' fees has been an area of ongoing media and public scrutiny.

In 2017, the Federal Government established a Ministerial Advisory Committee as part of a wider private health insurance review to address increasing concerns regarding out-of-pocket costs. On 1 March 2019, the Minister announced that the Government will fund the development of a national searchable website to provide the public with greater access to information about the costs of specialist services.

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

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

However, the proposed Government website allowing people to search specialists' fees will do nothing to inform patients about their likely out-of-pocket costs unless it also lists what patients can expect back from Medicare and their private health insurance fund.

8 Links to the AMA resources on Informed Financial Consent can be found on page 24

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

- which MBS item number is used for their particular operation;
- whether they are actually covered for that procedure;
- whether the doctor has an agreement with the health fund;
- what other doctors and tests are involved;
- whether the hospital has an agreement with the health fund;
- the benefit rate set by the fund; and
- what State they live in.

As demonstrated throughout this year's Report Card, a patient's out-of-pocket medical costs come from the doctor's fee and the benefit paid by a fund. These benefit rates are not uniform across insurers, procedures, States, and hospital setting.

To make sure that patients are not left out-of-pocket, medical practitioners must have multiple fee schedules (sometimes more than a dozen different rates) for a single procedure. They must do this to comply with the different rebates paid by each health fund to meet their no gap or known gap scheme requirements for that one procedure.

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

PRIVATE HEALTH INSURANCE REFORMS

What the reforms include

For the past two years, the Australian Government has been working on reforms to private health insurance. Some of the reforms were introduced in 2018, but most came into effect from 1 April 2019.

The reforms include the following changes:

- Private hospital cover will be classified into four tiers — Gold, Silver, Bronze, and Basic.
- Health insurers can offer:
  - new discounts for people aged 18 to 29 to make private health insurance more affordable;
  - higher excesses in exchange for lower premiums;
  - travel and accommodation benefits for people who have to travel long distances for hospital treatment;
- Improved access to mental health treatment by allowing people to upgrade their hospital cover without re-serving a waiting period.
- The Private Health Insurance Ombudsman has new powers to investigate complaints.

Health insurers have until 1 April 2020 to introduce new Gold, Silver, Bronze, and Basic tiers for their hospital policies.

What the reforms will mean for your cover

Changes to hospital cover			
What is the change	What does it do	When does it take effect	What it means for me
Gold/Silver/ Bronze/Basic Tiers of cover	Current hospital cover products will be categorised as Gold/Silver/Bronze or Basic.	1 April 2019 Health insurers have until 1 April 2020 to apply to all their products.	Basic – very little if any cover in private hospital. Provides cover in public hospitals as a private patient. Bronze – low cover Silver – medium cover Gold – full or top cover Basic Plus, Bronze Plus, and Silver Plus policies cover at least one category more than normal Basic, Bronze, or Silver policies. For example, a Silver Plus policy could include cover for joints which are mandated only under Gold policies.

Changes to hospital cover			
What is the change	What does it do	When does it take effect	What it means for me
Minimum standard clinical categories	Health funds will need to use standard clinical categories or medical definitions, which means the language used will be consistent and easy to understand across all policies.	1 April 2019 Health insurers have until 1 April 2020 to apply to all their products.	Clinical categories are types of hospital treatments described in a standard way. If a policy covers a certain clinical category, then it must cover everything described as part of the category – not only some things. For example, 'bone, joint and muscle' category, or 'heart and vascular system' category, previously this was not the case. This consistency should make policies easier to compare.
Increasing excess levels	Voluntary excess levels have been increased, allowing consumers to choose products with higher excesses in return for lower premiums.	1 April 2019	Maximum permitted excesses for private hospital insurance will be increased from: • $500 to $750 for singles; and • $1,000 to $1,500 for couples/ families. There is no requirement for consumers to move to products with higher excesses.
Age discounts	Funds can now offer a discount of 2 per cent on your premium for every year you're under 30, up to a maximum of 10 per cent for people aged 18 to 25. The discount will gradually reduce after you turn 41.	1 April 2019	The allowed discounts vary and generally depend on how old you are when you purchase a policy, or your age. Your insurer can choose to offer discounts as follows: Your age – Max discount 29 – 2% 28 – 4% 27 – 6% 26 – 8% 18-25 – 10%
Supporting mental health	Members can upgrade their cover to access higher level benefits without having to serve a waiting period.	1 April 2018	People with limited cover for mental health treatment can upgrade their hospital cover to access higher benefits (such as in-hospital psychiatric services) for these services without serving a waiting period. This exemption from the usual waiting period can be used on a one-off basis.

Changes to hospital cover			
What is the change	What does it do	When does it take effect	What it means for me
Travel and accommodation benefits for regional and rural consumers	To improve access to private health insurance for Australians living in regional and rural Australia, private health insurers will be able to offer travel and accommodation benefits under hospital cover.	1 April 2019	Insurers will be able to offer travel and accommodation benefits under hospital cover, instead of only under general treatment policies. It is not mandatory for private health insurers to offer travel and accommodation benefits, so you should check with your insurer to see if this is available for your policy.
Changes to Extras cover			
Changing coverage for some natural therapies	Some natural therapies will not be able to receive the private health insurance rebate. Insurers will then not be able to offer benefits for these therapies as part of a health insurance policy.	1 April 2019	The following natural therapies are no longer able to receive the private health insurance rebate as part of a general treatment policy: Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, Western herbalism, homeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi, and yoga.

Will the reforms make things easier?

Gold, Silver, Bronze, and Basic should, in theory, make choosing a policy simpler. Consumers should be aware that the proposed tiers are not the only options. Insurers can label their products as 'Plus', creating seven major categories, but they can choose what extra clinical categories they can add to these products, making an even greater number of choices.

However, the use of clinical categories and standard definitions means two things:

1. When you purchase a product, you know what you are covered for; and
2. It is easier to compare products across insurers.

This is an improvement. For example, under the previous rules an insurer could state that joints were included in mid-level hospital cover, but in the fine print this could have meant only shoulders and wrists, with the most common procedures (knee and hip) only being covered in their top-level policies. Often, it was only when people went to use their insurance that they found out what they really weren't covered for.

Ask your doctor which MBS item numbers your treatment falls under. Then you can clarify with your insurer whether your new policy covers this treatment/procedure.

BENEFIT SCHEDULES AND OUT-OF-POCKET COSTS

Each insurer has its own schedule of benefits it pays for admitted medical services (those carried out in day or night stay hospital). Not all insurers make this schedule available to the public.

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

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

When there is a difference between the doctor's fee and the insurance benefit, out-of-pocket costs can occur. It is a common misunderstanding that the doctor's fee is the reason for an out-of-pocket cost. As Table 3 reveals, 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. As Table 4 shows, it also varies from State to State.

Table 3 demonstrates the different benefit amounts paid by insurers for a select range of common procedures. Red indicates the lower level of benefits paid, and blue shows which insurers pay a higher level of benefits. The scale is relative to the other benefits paid for the same procedure across the listed insurers.

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

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

Table 3: **Benefits paid for select admitted medical services by different private health insurers as at 30 September 2019**

MBS Item	MBS Description	MBS Fee	Bupa	HCF no gap rate	AHM/ Medibank Private	NIB	AHSA	HBF no gap rate	Variation Lowest to highest
12203	Overnight Investigation for sleep apnoea	597.40	712.85	758.50	722.75	724.40	694.80	757.05	9% $63.70
13918	Cytotoxic Chemotherapy	99.50	119.60	128.30	121.35	113.15	109.70	129.10	18% $19.40
16519	Uncomplicated Delivery (of baby)	705.05	2068.15	2058.95	1917.15	1575.75	1630.30	2161.45	37% $585.70
16522	Complicated Delivery (of baby)	1655.40	2432.70	2408.00	2233.65	2336.25	2149.10	2675.20	24% $526.10
30445	Cholecystectomy	751.20	1078.10	1083.15	1069.25	1017.25	1115.60	1031.65	10% $98.35
30572	Appendicectomy	452.55	649.50	652.50	653.05	611.65	645.50	621.60	7% $41.40
30609	Femoral or Inguinal Hernia	471.95	677.30	680.50	675.65	637.85	932.00	648.05	46% $294.15
31500	Breast, benign lesion surgical biopsy or excision	264.20	389.05	380.95	389.55	357.05	363.70	359.35	9% $32.50
32090	Colonoscopy	339.70	480.90	473.10	449.60	439.60	443.70	461.80	9% $41.30
32139	Haemorrhoidectomy	373.65	528.95	520.35	531.80	483.50	616.70	508.15	28% $133.20
32500	Varicose Veins	111.55	168.10	165.80	174.40	151.85	168.40	151.70	15% $22.70
35657	Vaginal Hysterectomy	685.50	1102.50	1129.45	1122.70	1033.35	1090.10	1263.65	22% $230.30
37623	Vasectomy	233.55	361.05	360.85	378.35	356.70	351.30	320.90	18% $57.45
38306	Stent for coronary artery	774.55	1123.15	1111.75	1138.30	1044.55	1287.90	1169.45	23% $243.35
38500	Coronary Artery Bypass	2235.20	3361.80	3432.00	3479.10	3140.00	3871.40	3700.40	23% $731.40
39331	Carpal Tunnel Release	281.25	464.25	469.20	471.20	426.40	450.10	463.50	11% $44.80
39709	Craniotomy	1612.15	2658.10	2689.55	2487.70	2444.15	2474.10	2657.15	10% $245.40
41789	Tonsils or Tonsils and Adenoids	300.45	492.00	561.85	495.90	450.65	526.00	526.80	25% $111.20
42702	Cataract Surgery	772.80	1211.25	1293.10	1144.25	1169.00	1267.90	1254.40	13% $148.85
49318	Hip Replacement	1338.90	2142.20	2503.80	2032.80	2056.65	2265.60	2167.85	23% $471.00
49518	Knee Replacement	1338.90	2142.20	2503.80	2032.80	2056.65	2626.10	2167.85	29% $593.30

Highest benefit paid — Lowest benefit paid

1	2	3	4	5	6	7	8

Gaps/Out-of-pocket costs

Health insurers may have different benefit amount schedules for each State and Territory, as outlined in Table 4. If an insurer has a higher percentage of medical services covered at no gap compared with another insurer (in the same State or Territory), it is a signal that the first insurer has a more effective no gap 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.[9]

Table 4 shows the amount paid by one insurer (Bupa) for the same medical service provided in different parts of Australia can vary by up to 32 percent for a single MBS Item (MBS Item 13918 cytotoxic chemotherapy). Additionally, Bupa currently pays a benefit amount of $3061.25 for a craniotomy (MBS Item 39709) performed in Tasmania, which is $481.85 more than the $2579.40 paid for the same surgery performed in Queensland. The same insurer pays $1370.30 in Victoria for a stent for a coronary artery (MBS Item 38306), which is $247.15 more than the $1123.15 paid across the border in New South Wales.

Tables 7 and 8 show the likelihood of medical services being provided under a no gap arrangement by health insurer in each State and Territory.

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

Table 4: Benefits paid by Bupa for select admitted medical services by State/Territory as at 30 September 2019

MBS Item	MBS Description	MBS Fee	NSW/ACT	VIC	WA	QLD	SA	TAS	NT	Variation Lowest to highest
12203	Overnight Investigation for sleep apnoea	597.40	712.85	851.75	713.90	711.65	840.05	711.65	711.65	20% $140.10
13918	Cytotoxic Chemotherapy	99.50	119.60	140.30	119.80	106.05	138.35	106.00	106.05	32% $34.25
16519	Uncomplicated Delivery (of baby)	705.05	2068.15	2194.20	2104.30	2064.20	2271.05	2057.55	2101.55	10% $213.50
16522	Complicated Delivery (of baby)	1655.40	2432.70	2484.80	2286.65	2283.60	2547.35	2280.50	2285.35	12% $266.85
30445	Cholecystectomy	751.20	1078.10	1227.75	1078.10	1078.10	1227.75	1078.10	1173.50	14% $149.65
30572	Appendicectomy	452.55	649.50	739.85	649.50	649.50	739.85	649.50	706.95	14% $90.35
30609	Femoral or Inguinal Hernia	471.95	677.30	771.10	677.30	677.30	771.10	677.30	737.20	14% $93.80
31500	Breast, benign lesion surgical biopsy or excision	264.20	389.05	431.90	389.05	379.15	431.90	379.15	408.35	14% $52.75
32090	Colonoscopy	339.70	480.90	536.95	480.90	480.90	531.40	480.90	480.90	12% $56.05
32139	Haemorrhoidectomy	373.65	528.95	590.65	528.95	528.95	584.55	528.95	528.95	12% $61.70
32500	Varicose Veins	111.55	168.10	195.85	168.10	166.20	190.05	177.20	168.10	18% $29.65
35657	Vaginal Hysterectomy	685.50	1102.50	1118.60	1102.50	1055.65	1118.60	1055.65	1055.65	6% $62.95
37623	Vasectomy	233.55	361.05	396.85	361.05	380.05	336.30	361.05	361.05	18% $60.55
38306	Stent for coronary artery	774.55	1123.15	1370.30	1156.15	1133.70	1334.50	1146.75	1180.25	22% $247.15
38500	Coronary Artery Bypass	2235.20	3361.80	3666.45	3361.80	3361.80	3420.95	3361.80	3361.80	9% $304.65
39331	Carpal Tunnel Release	281.25	464.25	464.25	464.25	450.00	512.25	533.80	490.55	19% $83.80
39709	Craniotomy	1612.15	2658.10	2658.10	2658.10	2579.40	2936.50	3061.25	2782.75	19% $481.85
41789	Tonsils or Tonsils and Adenoids	300.45	492.00	532.20	492.00	492.00	474.70	492.00	492.00	12% $57.50
42702	Cataract Surgery	772.80	1211.25	1413.20	1214.70	1263.75	1245.60	1195.60	1194.75	18% $218.45
49318	Hip Replacement	1338.90	2142.20	2489.95	2142.20	2142.20	2449.90	2410.55	2142.20	16% $347.75
49518	Knee Replacement	1338.90	2142.20	2489.95	2142.20	2142.20	2449.90	2410.55	2142.20	16% $347.75

Highest benefit paid — Lowest benefit paid

1	2	3	4	5	6	7	8

State-based comparison of gaps

This section of the Report Card provides information on 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) (see Tables 5 and 6).
- The percentage of medical services provided at no gap. This is the percentage of the doctor's fees paid by that insurer that are provided with no gap (see Tables 7 and 8).

As demonstrated in Tables 5-8, this information is broken down by insurer on a State basis because the value of some insurers' gap schemes and benefits schedules can differ between States, and these differences are not apparent in the national figures.

Table 5: Percentage of hospital-related charges covered by State – Open membership funds

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT
Australian Unity	83.6%	87.3%	90.9%	88.6%	91.0%	88.8%	89.1%	82.6%
Bupa	81.2%	88.9%	92.8%	90.8%	95.2%	88.4%	93.8%	90.8%
CBHS Corporate	70.9%	87.1%	85.0%	95.2%	80.5%	96.6%	n/a	n/a
CDH	25.5%	96.4%	93.3%	78.2%	95.9%	71.7%	99.2%	n/a
CUA Health	80.6%	88.6%	90.1%	92.0%	88.2%	89.0%	88.8%	81.0%
GMHBA	73.8%	80.7%	89.9%	84.4%	88.3%	87.6%	88.0%	83.6%
GU Health Corporate	85.6%	86.2%	88.9%	89.4%	89.9%	88.6%	89.5%	88.1%
HBF	84.7%	90.3%	93.5%	88.7%	94.0%	96.1%	95.9%	91.7%
HCF	87.7%	93.2%	93.4%	92.4%	95.1%	90.4%	93.4%	91.5%
HCI	96.7%	89.1%	94.2%	90.8%	94.2%	95.2%	95.7%	100%
Health.com.au	73.7%	81.0%	83.9%	83.8%	83.8%	84.5%	88.3%	85.1%
Health partners	82.0%	89.0%	91.4%	91.5%	95.6%	89.9%	94.9%	90.9%
HIF	79.2%	86.9%	91.6%	90.3%	93.2%	92.2%	90.0%	86.5%
Latrobe	84.3%	88.0%	92.0%	91.6%	89.3%	89.9%	91.4%	87.8%
MDHF	84.2%	94.7%	94.4%	91.1%	89.1%	88.9%	97.4%	98.4%
Medibank	83.1%	89.4%	92.4%	89.9%	93.6%	90.4%	93.6%	90.0%
NIB	76.1%	87.4%	85.6%	84.2%	90.6%	84.9%	88.8%	78.0%
Onemedifund	93.7%	92.7%	95.0%	93.7%	96.4%	94.5%	94.7%	n/a
Peoplecare	80.1%	91.7%	92.8%	90.6%	92.9%	90.7%	93.2%	91.7%
Phoenix	88.5%	94.1%	93.9%	93.1%	97.8%	94.0%	97.6%	89.6%
QCH	60.7%	90.8%	91.2%	89.5%	95.1%	90.8%	91.5%	80.9%
St Lukes	81.8%	93.2%	93.4%	91.4%	95.7%	86.3%	95.2%	48.5%
Transport Health	90.4%	89.9%	94.3%	91.2%	94.7%	95.0%	92.6%	n/a
Westfund	86.8%	92.1%	96.3%	92.1%	97.0%	95.5%	92.2%	82.7%

Source: Private Health Insurance Ombudsman (PHIO): State of the Health Funds Report 2018. This report was published in March 2019. The next update will be in 2020.

Table 6: Percentage of hospital-related charges covered by State – restricted membership funds

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT
ACA	88.2%	94.3%	96.9%	92.4%	94.9%	97.9%	89.3%	n/a
CBHS	84.8%	90.2%	94.3%	93.0%	95.8%	92.8%	95.6%	96.0%
Defence Health	84.3%	91.0%	93.7%	92.5%	94.8%	93.1%	94.7%	93.3%
Doctors' Health	90.8%	91.7%	92.3%	92.0%	89.5%	90.9%	91.7%	89.6%
Emergency Services	100%	93.1%	95.0%	96.5%	98.1%	94.4%	98.1%	78.7%
MO Health	56.6%	84.1%	84.8%	85.4%	81.9%	83.7%	67.3%	n/a
Navy Health	86.6%	91.8%	93.4%	92.8%	94.0%	94.7%	95.1%	94.0%
Nurses and Midwives	50.4%	87.3%	89.9%	87.9%	89.9%	90.8%	94.0%	n/a
Police Health	91.2%	90.9%	93.6%	92.6%	97.7%	93.7%	95.7%	92.7%
Reserve Bank	93.3%	92.5%	97.8%	97.2%	99.4%	97.1%	99.0%	n/a
RT Health Fund	72.2%	94.3%	93.0%	93.3%	95.6%	93.8%	89.5%	92.9%
Teachers' Health	86.7%	91.6%	93.0%	92.7%	94.3%	91.6%	94.2%	92.8%
TUH	89.8%	92.7%	90.6%	92.3%	94.6%	92.9%	96.6%	95.9%

Source: Private Health Insurance Ombudsman (PHIO): State of the Health Funds Report 2018
Open member funds provide policies to the general public; restricted member funds offer policies only to specific groups.
'n/a' signifies no activity in that state. 100 per cent is likely to indicate small numbers (e.g. only 1 episode).

Table 7: Percentage of medical services with no gap – open member funds

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT
Australian Unity	84.2%	91.3%	92.0%	92.3%	92.6%	88.5%	90.7%	82.1%
Bupa	81.9%	88.6%	89.0%	88.9%	88.8%	85.0%	89.5%	86.6%
CBHS Corporate	85.7%	67.8%	34.6%	96.0%	59.3%	89.7%	n/a	n/a
CDH	n/a	88.1%	59.3%	66.0%	70.8%	59.1%	65.2%	n/a
CUA Health	82.3%	91.0%	90.9%	94.2%	86.9%	88.7%	90.5%	86.7%
GMHBA	50.9%	74.6%	80.1%	81.3%	80.0%	70.8%	78.3%	61.0%
GU Health Corporate	83.1%	86.6%	88.8%	89.7%	90.6%	83.4%	85.3%	96.0%
HBF	45.3%	43.1%	34.8%	36.4%	36.0%	87.9%	38.9%	26.2%
HCF	80.2%	91.1%	89.5%	92.0%	90.3%	86.7%	88.8%	88.9%
HCI	91.4%	85.9%	90.4%	90.7%	90.7%	90.3%	92.3%	100%
Health.com.au	74.1%	84.7%	86.7%	87.6%	83.1%	85.3%	90.8%	89.3%
Health partners	85.0%	91.2%	89.5%	94.0%	93.1%	83.7%	98.1%	86.5%
HIF	69.5%	84.8%	87.7%	88.3%	87.0%	86.3%	86.8%	78.8%
Latrobe	45.1%	78.4%	77.7%	81.8%	84.9%	67.5%	74.2%	34.4%
MDHF	28.6%	84.1%	82.6%	80.1%	79.7%	76.7%	88.3%	75.7%
Medibank	80.0%	88.4%	85.1%	88.6%	89.9%	72.1%	92.1%	82.9%
NIB	66.2%	92.6%	91.4%	85.9%	93.6%	81.8%	85.3%	77.2%
Onemedifund	56.5%	89.6%	92.7%	94.5%	90.7%	82.7%	92.3%	n/a
Peoplecare	78.6%	92.5%	90.8%	91.5%	90.7%	87.4%	93.6%	85.1%
Phoenix	81.3%	92.3%	90.4%	90.8%	93.7%	86.7%	92.6%	83.9%
QCH	60.8%	93.2%	91.8%	91.7%	90.8%	85.5%	85.7%	72.5%
St Lukes	74.2%	87.2%	83.1%	76.9%	85.9%	79.7%	91.2%	60.0%
Transport Health	70.8%	88.5%	92.5%	91.2%	94.5%	90.6%	73.0%	n/a
Westfund	59.4%	92.4%	93.0%	89.4%	92.3%	88.0%	76.8%	86.3%

Table 8: Percentage of medical services with no gap – restricted member funds

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT
ACA	89.2%	91.1%	93.5%	94.0%	93.9%	92.9%	95.4%	n/a
CBHS	85.0%	89.0%	90.9%	92.4%	90.7%	85.6%	93.1%	87.2%
Defence Health	79.5%	89.3%	91.1%	92.4%	90.3%	88.0%	91.4%	88.7%
Doctors' Health	87.2%	92.4%	93.4%	94.1%	91.0%	90.8%	88.5%	76.9%
Emergency Services	100%	88.8%	93.0%	91.5%	89.4%	81.5%	66.7%	54.2%
MO Health	75.0%	84.8%	85.4%	91.7%	93.8%	75.8%	14.3%	n/a
Navy Health	82.6%	90.4%	91.9%	91.8%	93.3%	88.3%	92.6%	86.9%
Nurses and Midwives	76.5%	85.1%	84.3%	90.7%	86.9%	86.9%	80.3%	n/a
Police Health	80.5%	87.7%	86.7%	88.8%	90.9%	81.7%	89.2%	83.3%
Reserve Bank	79.2%	91.4%	93.3%	95.7%	97.8%	90.2%	92.7%	n/a
RT Health Fund	86.9%	93.4%	91.4%	93.5%	90.8%	87.3%	91.1%	84.8%
Teachers' Health	82.0%	90.5%	90.7%	92.7%	89.9%	86.1%	92.8%	89.8%
TUH	86.9%	91.2%	85.1%	93.1%	86.7%	89.2%	96.2%	98.2%

TRENDS IN PRIVATE HEALTH INSURANCE

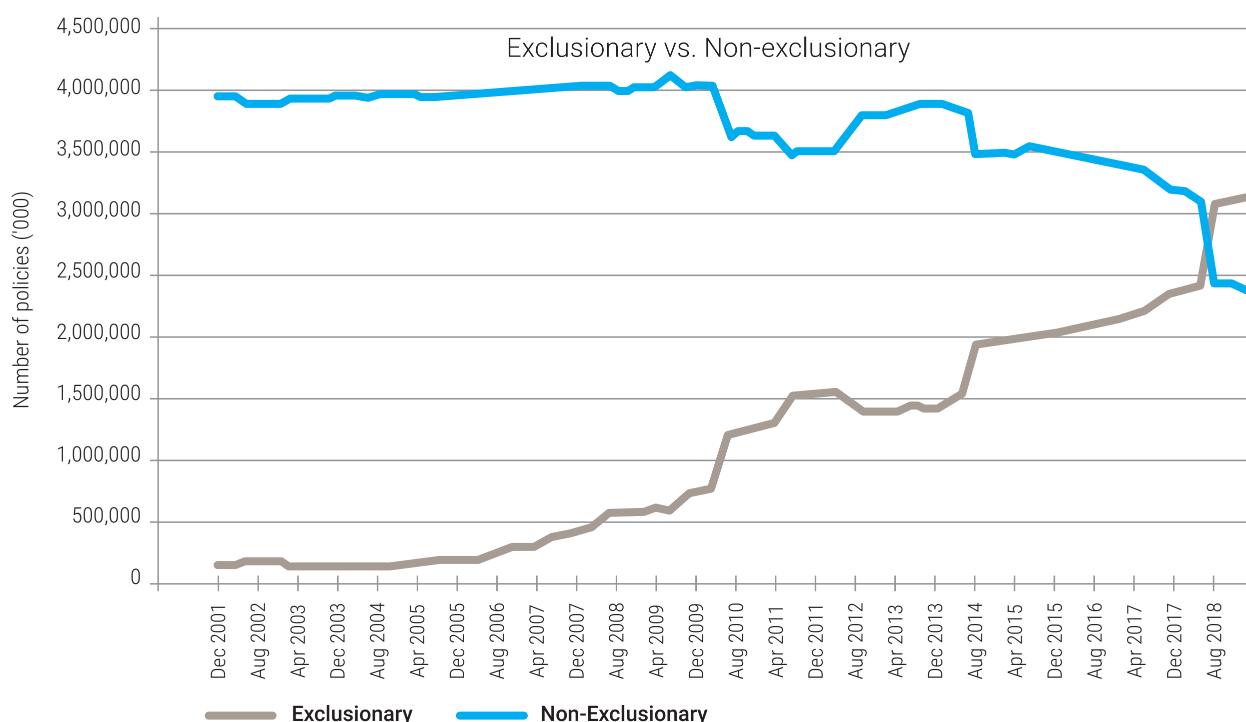
Change in exclusions

An exclusion for a particular condition means a policy holder is not covered for treatment as a private patient in a private or public hospital for those particular conditions listed. Over time, the number of policies containing exclusions has grown significantly. In 2018, the number of policies with exclusions overtook the number without. (Figure 1)

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

As Figure 1 shows, virtually no policies had exclusions only 15 years ago. In 2018, for the first time, a majority of policies contain exclusions.

Figure 1: Change in private health insurance exclusionary and non-exclusionary policies (2001-2018)[10]



Source: Australian Prudential Authority – Operations of Private Health Insurers Annual Report 2009 – 2018

In this last year, 653,050 policies swapped from being rated as non-exclusionary to exclusionary in a single quarter[11]. The Department of Health understands that it is a consequence of insurer decisions to replace policy restrictions with exclusions across a range of hospital policies from 1 July 2018. The AMA believes this is a result of the process of aligning with the requirements of Gold, Silver, and Bronze, which requires covering all of a particular clinical category.

10 This graph is based on the work of Greg Jericho (https://www.theguardian.com/business/grogonomics/2018/feb/06/is-private-health-insurance-a-con-the-answer-is-in-the-graphs)

11 APRA Private Health Insurance Membership Trends June 2019 XLSX

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 problems and enquiries.

As part of the reforms announced in 2018, PHIO received additional resources to investigate complaints and other issues, and the Government announced significant improvements to the information statements provided by insurers – the Private Health Insurance Statement (called a PHIS – see page 23 for details). This will be overseen by PHIO.

In spite of fluctuations in total numbers, the greatest level of problems that consumers experience continues to be across a small number of constant issues (see Figure 2). The highest number of complaints have centred on benefits (non-payment or delayed payment, gaps paid); rate increases; membership issues; waiting periods for pre-existing conditions; and service, including information provided that doesn't meet consumer needs.

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

Moreover, online detail about a policy or information in brochures can be challenging to understand without a high level of health literacy.

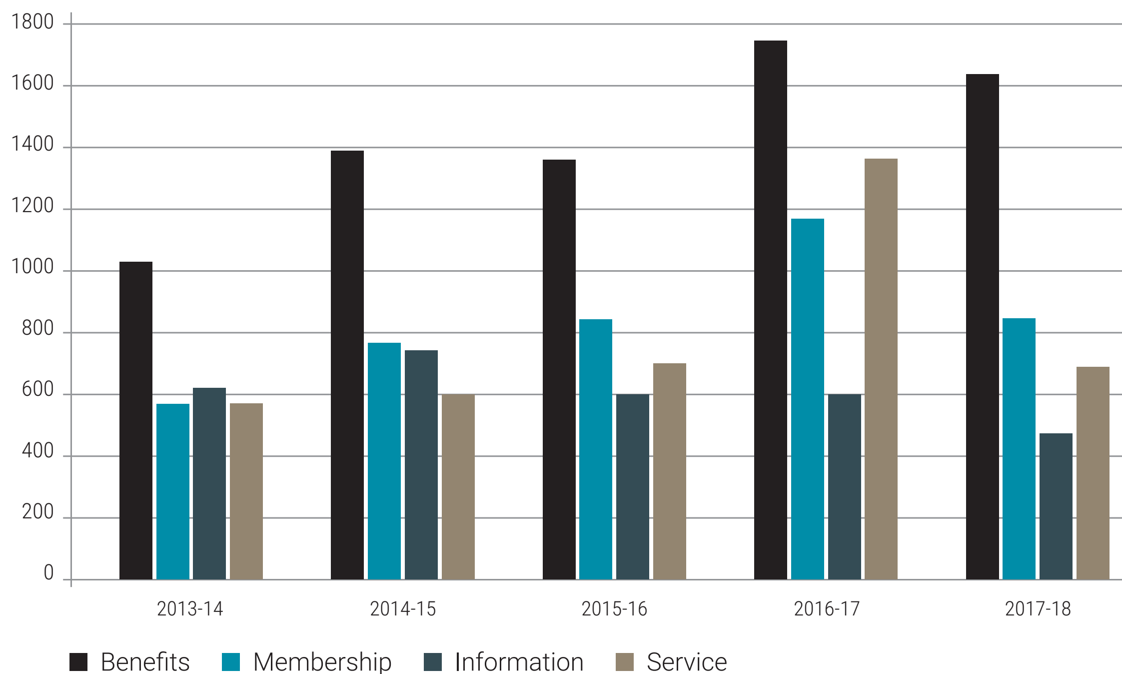
The AMA recommends that consumers with queries about their private health insurance speak to their insurer in the first instance, with confirmation provided in writing.

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

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

In the recent reforms, the PHIO was given new powers to investigate complaints and other issues. It was also given funding to upgrade and enhance its website privatehealth.gov.au, and has also released a simple comparison tool to help compare health insurance products.

Figure 2: PHIO complaints, by issue, 2013–14 to 2017–18



Source: ACCC Report to the Australian Senate – On anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2017 to 30 June 2018 (https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2017-18 - Figure 2 p8).

Private Health Information Statement (PHIS)

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

From 2019 onwards, policy information for new Gold, Silver, Bronze, or Basic hospitals and new general treatment policies will be sent to members in the form of a PHIS that includes information about what is and is not covered, based on the new tiers and clinical categories of treatment. From 1 April 2020, all policies will be summarised in the PHIS documents.

People will be able to search for and compare a standard PHIS from every insurer in Australia on the Government website www.privatehealth.gov.au.

MORE INFORMATION ABOUT PRIVATE HEALTH INSURERS AND THEIR PRODUCTS

AMA Resources

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

- Setting Medical Fees and Billing Practices (2017) https://ama.com.au/position-statement/setting-medical-fees-and-billing-practices-2017.
- Informed Financial Consent position statement (2015) https://ama.com.au/position-statement/informed-financial-consent-2015.
- Informed Financial Consent - a collaboration between doctors and patients (2019).

  Assisting patients to understand their health care and its costs https://ama.com.au/article/ama-informed-financial-consent.

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

Commonwealth Government information

The Commonwealth Government hosts a website that provides:

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

www.privatehealth.gov.au

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 a number of 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 website at http://www.ombudsman.gov.au/How-we-can-help/private-health-insurance.

MBS Online

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

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