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Dear Ms Radcliffe

Inquiry into the Value of Private Health Insurance and Out-of-pocket costs in Australia, 31 October 2017

Thank you for the questions on notice from Senator Griff. The question and answers are below.

Q1. What proportion of AMA members would charge above the AMA fee?

It is unknown what proportion of members charge above the AMA for any particular service. The AMA fees list is a guideline only and medical practitioners should satisfy themselves in each individual case as to a fair and reasonable fee having regard to their own practice cost experience and the particular circumstances of the case and the patient. The APRA data shows the majority of services in hospital are provided at a no or known gap amount (88.10% and 7.10% respectively). The benefit amounts paid under these arrangements are set by the insurers, not by the AMA. Further they can vary significantly between funds, with some funds paying far less than others for the same procedure.

Utilisation of the AMA Fees List is not restricted to AMA members, although non-members must pay a licence fee to access the information.

Q2. Has the AMA done any audit or evaluations of fees and compliance with informed financial consent provided by doctors?

The AMA is a member based organisation. It does not have any regulatory powers to conduct audit functions. However when surveyed, 90%¹ of AMA member practitioners stated that they find out if a patient has private health insurance, as a part of the conversation about the likely fees for treatment. This information is an important part of an informed financial consent processes. Over 86.8% of AMA member practitioners surveyed take their patients financial situation into account when setting the fee for treatment. Finally, the vast majority (76.1%) advise their patients to check their private health insurance cover prior to treatment.

¹ 2017 survey of AMA specialist private practitioner members: response rate of over 1000

Q3. You point out that benefit schedules are different for each fund and therefore lead to more confusion for consumers. Minimum benefit levels are mandated at the MBS fee. Should this be increased to the no gap fee?

The no-gap benefits schedule is set by individual private health insurers and these vary considerably. The MBS sets a benchmark that private health insurers can respond to. Mandating a minimum amount at the no-gap amount may change the benefits paid by insurers and does not help consumers, unless benefit schedules are published. In addition, a significant amount of services (88.10%) are provided at the no-gap rate, increasing the minimum benefit to the no-gap fee would not benefit the vast majority of consumers.

Q4. The AMA recommends that private health insurers should be required to publish their schedules of medical benefits in a way that is easily accessible to consumers and comparable with each other.

Would this be a website where consumers could search the benefit for an item prior to joining a fund?

The AMA does not have a preferred model for improved transparency for benefits schedules. However these schedule should be easy to locate and readily comparable for consumers.

Q5: Would health funds then need to provide more than 12 months' notice of benefit changes? As there is a 12-month waiting period before benefits for hospitalisation are payable?

It would be ideal if policy coverage did not change post purchase - ever. However, given change in technology, the underpinning Medicare Benefits Schedule and other industry factors, this is probably unrealistic. The proposed reforms to private health insurance might assist in making coverage more consistent.

Given that the majority of changes by the insurers are to remove benefits, it seems fair that the same waiting periods apply for changes to benefits either by the consumer or the insurer. Furthermore, such communication needs to be clear and simple – and avoid use of complicated language and technical definitions.

Yours sincerely

Dr Michael Gannon
President