Supplementary submission to the House of Representatives Standing Committee on Health, Aged Care and Disability

Inquiry into Access and Affordability of Medical Specialists in Australia

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This supplementary submission addresses one matter not covered in the primary submission submitted on 14 April 2026: the inadequate indexation of private health fund benefit rates within gap arrangements for anaesthesia services, and the related emergence of enhanced no-gap programs that represent the early architecture of managed care. This supplementary should be read alongside the primary submission but is drafted to stand alone.

Background: anaesthetic fee calculation and the RVG

Unlike surgical or consultation fees, anaesthetic fees are not a single quoted price. They are calculated using the Medicare Benefits Schedule Relative Value Guide (RVG), a unit-based system in which each anaesthetic episode attracts a number of units reflecting the complexity of the procedure and the duration of the anaesthetic. The total fee is determined by multiplying those units by a dollar value per unit, the unit rate. The unit rate is therefore the key variable in determining both what an anaesthetist charges and what a fund contributes under any known-gap arrangement.

Private health funds publish their own unit rates for known-gap arrangements. These sit above the CMBS rate and represent the fund's enhanced contribution when a practitioner participates in a known-gap scheme. The difference between the fund's unit rate and the practitioner's unit rate, applied across the total units for an episode, determines the patient's out-of-pocket cost.

The double erosion problem

Section 9 of the primary submission identified that the known-gap threshold of approximately $500 per doctor per episode of care has not been meaningfully updated in over a decade. There is a further and distinct problem that submission did not address explicitly: the fund benefit rates paid within that threshold have themselves been inadequately indexed over the same period.

The result is a double erosion. The threshold has not moved. The fund's unit rate within the threshold has declined in real terms. Practice costs have risen. All three forces operate simultaneously and in the same direction, away from gap scheme participation and toward unstructured total fee billing, with patients absorbing the consequence.

It is also worth noting that the fund's contribution within a known-gap arrangement does not stand alone. For an admitted patient, Medicare pays 75 per cent of the CMBS fee for the medical practitioner's professional services regardless of whether a known-gap arrangement applies. The fund's enhanced benefit sits on top of that fixed Medicare component. When a fund's contribution defaults back to the CMBS schedule fee, because the practitioner has charged outside the known-gap threshold, the Medicare 75 per cent component does not change. The fund's saving from defaulting to CMBS is therefore extracted entirely from the practitioner and the patient. Medicare receives no benefit from the fund's withdrawal. This means the fund retains complete discretionary control over the indexation of its own enhanced contribution, while bearing no proportional risk when that contribution is withdrawn. The structural asymmetry between Medicare's regulated component and the fund's discretionary component is itself a feature of the system that has received insufficient attention.

The data: Medibank GapCover unit rates 2017 to 2025

The Australian Society of Anaesthetists collates and publishes annually the fund benefit rate schedules of the major private health insurers as a reference resource for members, and separately publishes a recommended maximum monetary value per RVG unit calculated using the AMA Medical Fees Index. The following data for Medibank GapCover, expressed as the dollar value paid per RVG unit, is drawn from those collated schedules and from Medibank's own billing documentation.

Year	CMBS rate	Medibank GapCover rate
2017	$19.80	$32.70
2018	$19.80	$32.70
2019	$20.10	$33.20
2020	$20.40	$33.70
2021	$20.60	$34.00
2022	$20.95	$34.60
2023	$21.80	$36.00
2024	$22.55	$37.25
2025	$23.10	$38.15

From 2017 to 2025 the Medibank GapCover unit rate increased from $32.70 to $38.15, nominal growth of 16.7 per cent over eight years against cumulative CPI growth of approximately 25 to 30 per cent over the same period. The AMA fee schedule, which tracks actual practice cost growth, moved from $91.00 per unit in 2021 to $106.00 in 2024 alone, an increase of 16.5 per cent in three years.

Funds have coalesced toward similar rates

Medibank is used here by way of example because the eight-year dataset is most readily available. The pattern is not specific to Medibank. As with the $500 known-gap threshold, the major funds have coalesced toward similar known-gap unit rates. The 2025 rates published in ASA schedules show:

- Medibank Private GapCover: $38.15
- Bupa Known Gap: $38.25
- AHSA Access Gap Cover: approximately $38.48 with minor state variation
- HCF Medicover: $38.10
- St Luke's Health Medical Gap: $39.75

The variation between funds is small, under two dollars per unit across the major insurers. Practice costs vary substantially more than that across the country and across specialties. The convergence of fund rates within such a narrow band, against a backdrop of materially divergent practice cost pressures, is not what genuine competition between insurers on benefit generosity would produce. It is what tacit alignment on a fund-favourable rate produces. The pattern mirrors the convergence on the $500 known-gap threshold identified in the primary submission. Both represent fund-favourable settlement points reached without meaningful negotiation and maintained without effective indexation.

Published rates do not produce informed patient choice

The unit rates discussed above are published in fund schedules and provider documentation. Their existence in the public domain should not be confused with patient understanding of their implications. Patients selecting a private health insurance product have no practical way to compare the anaesthetic benefit performance of different funds. Anaesthesia is unusual in that the RVG unit rate makes a fund's contribution directly comparable across insurers and across years. A single number — the dollar value per unit — captures the fund's benefit performance for any anaesthetic episode, whatever its complexity or duration. This permits straightforward comparison between funds and clear tracking of indexation over time. For other specialties, by contrast, funds pay variable amounts above the CMBS schedule fee for different procedures, with no published methodology and no consistent relationship between procedures, making comparable assessment between funds effectively impossible. Yet even the comparative transparency available in anaesthesia does not translate into informed patient choice at the point of fund selection. The data exists, but it is not signposted to consumers, is not material to fund marketing, and cannot reasonably be navigated by a patient choosing between products.

A historical example is illustrative. For an extended period nib operated without any known-gap scheme. The only available pathway was payment at the No Gap rate, or where a practitioner charged above that rate, the patient receiving only the CMBS schedule fee from the fund. When practitioners quoted nib patients during that period, the standard explanation was that the larger gap was a direct consequence of nib's own policy, and that a different fund offering a known-gap arrangement might better suit the patient's circumstances. This information was generally provided at

the point of consent, after the fund had already been chosen, when the patient could do little with it for the current episode but a great deal for future fund selection. nib subsequently introduced a known-gap scheme.

The episode is significant for two reasons. First, it suggests that patient pressure can shift fund behaviour when patients are equipped with information they cannot otherwise obtain. Second, it suggests that the mechanism by which such information currently reaches patients is the clinical relationship at the point of consent, after the fund has been selected, rather than at the point of fund selection where it would be most useful. This is consistent with the primary submission's broader argument that current transparency mechanisms operate too late in the patient journey to produce genuine informed choice.

Enhanced no-gap arrangements: unilateral fee setting and the trajectory toward managed care

Two distinct but related models warrant the committee's attention.

The first is whole-of-practice mandatory networks. nib's GapSure Anaesthetics network describes its offer as providing 'more certainty in billing through a single, uniform unit value' and 'greater certainty' for patients. The current rate is $45 per unit. Registration is voluntary, but once a practitioner registers, the network applies to all eligible nib patients across all locations, with no case-by-case discretion. A discretionary known gap of up to $500 is permissible only for procedures with five or more RVG base units. Determining whether registration produces a better financial outcome than the alternative requires modelling a year of practice billing data under both fee structures, accounting for the base-unit threshold, the mandatory no-gap component, and the indexation trajectory of each, in circumstances where individual case mix can shift materially within a year. This analysis is effectively beyond the means of the individual practitioner. The fund undertakes the equivalent analysis at population scale before setting the rate. The voluntary choice is therefore offered on terms of significant information asymmetry.

The second is site and procedure specific no-gap programs. Hospital networks in conjunction with health funds including HCF, Medibank and nib offer zero out-of-pocket procedures at participating hospitals across a defined list of specialties, currently joint replacements, ACL repair, hernia surgery, and endoscopy, with surgeon, anaesthetist and hospital each contracted into the program for those specific procedures at those specific sites. Patients are steered to participating networks via the financial incentive of zero out-of-pocket cost.

Both models are presented as patient benefits and in their immediate effect they are. Patients pay nothing. Surgery is delivered. The clinical care is no different.

The structural concerns are not about the immediate patient experience.
First, the rates are set unilaterally by the fund. There is limited scope for negotiation between parties of equal bargaining power. The fund publishes a rate; the practitioner accepts or declines. The "better payment" presented to practitioners is set at a level the fund considers commercially advantageous, not at a level reflecting the actual cost of providing the work. Where rates are indexed at all, indexation

tracks MBS movements rather than practice cost growth, and the data presented earlier in this submission demonstrates those are not the same.

Second, participation may be practically constrained in many settings. Once registered with a whole-of-practice network, the practitioner cannot opt out for individual patients. In site and procedure specific programs, where the principal specialist and hospital have contracted into the arrangement, the anaesthetist working that list faces significant practical pressure to participate regardless of whether the rate is workable for their individual practice. Clinical autonomy is preserved in contractual terms; the commercial reality of working relationships does not preserve it in the same way.

Third, and most significantly for the committee, these programs taken together represent the early architecture of managed care. The fund determines which procedures are eligible, at which sites, performed by which providers, at what rate, with patients directed toward participating networks via the financial steering mechanism of zero out-of-pocket cost. Each individual program looks like a discrete commercial arrangement and a patient benefit. Aggregated across the system the trajectory is increasingly apparent. The fund is progressively positioning itself as the price-setter, the network gatekeeper, and the arbiter of where and how care is delivered.

Australia has not had a substantive national debate about whether managed care is the direction we want our private health system to take. It is happening anyway, program by program, contract by contract, beneath the threshold at which it would be recognised as a structural change.

International experience with managed care models is also worth noting. The health systems internationally most associated with managed care produce among the highest costs in the developed world and outcomes that compare unfavourably with both publicly funded universal systems and well-regulated hybrid systems. Whether Australia's drift in this direction is intended, and whether it is supported by evidence of better patient outcomes, are questions the committee may wish to examine.

The connection to the primary submission's reform proposals

The primary submission proposed that stronger minimum benefit-return ratios be considered for private health insurers to ensure premium growth translates more directly into patient care. The inadequate indexation of gap benefit rates is connected to that proposal but raises a more fundamental structural question. A fund that grows premium revenue while allowing its benefit contributions to decline in real terms is extracting value from the premium pool rather than returning it. The $500 known-gap threshold, the unit rates paid within it, and the rates offered through enhanced no-gap programs are all instruments of that extraction, at scale.
Gap cover arrangements are not regulated benefits. The only mandated medical benefit funds must pay for in-hospital services is the 25 per cent of CMBS that sits above the Medicare rebate. Everything above that, the enhanced unit rate, the known-gap threshold, the entire gap cover architecture, is a voluntary commercial product the fund can withdraw or erode at any time without regulatory consequence.

The current arrangement is structurally unstable. Patients believe they hold meaningful protection because gap cover schemes exist and are marketed as a feature of their cover. The schemes can be progressively hollowed out, as the data in this submission demonstrates is occurring, without breaching any regulatory minimum.

The committee may therefore wish to consider not only stronger minimum benefit-return ratios but whether some component of gap protection should itself be mandated as a condition of writing private hospital cover, with regulated indexation tied to a published cost index. Without that, headline benefit ratios can be maintained while the real value of patient protection erodes through fund discretion that current regulation does not constrain.

Funds may argue that mandating any component of gap protection would be unaffordable in the context of broader cost pressures across the private health system. This argument should be examined against the funds' own expenditure structure. APRA data for the September 2025 quarter shows that of $5,208.58 million in hospital treatment benefits, hospital services such as accommodation and nursing accounted for $3,797.65 million (approximately 73 per cent), medical services accounted for $771.00 million (approximately 15 per cent), and medical devices and human tissue items accounted for $639.94 million (approximately 12 per cent).

Within the medical services category, APRA data on the specialty composition of medical benefits indicates that anaesthesia accounts for approximately 25 per cent, pathology and diagnostic services together approximately 12 per cent, and the procedural surgical specialties that dominate public debate about specialist fees (orthopaedic, general surgical, ophthalmology, cardiothoracic, urology and others) sum to approximately 30 to 32 per cent. Translated to total fund hospital benefit expenditure, this means anaesthesia represents approximately 3.7 per cent, the procedural surgical specialties together represent approximately 4.5 per cent, and the entire treating specialist workforce that is the focus of public affordability debate represents under 10 per cent of total fund hospital benefit expenditure.

The marginal cost of indexing gap protection adequately is therefore a small fraction of a small fraction of total benefit expenditure. Funds choose not to fund gap cover adequately not because they cannot afford to but because they are not required to. The committee may wish to seek both the APRA quarterly benefit data and the specialty composition breakdown directly from the funds before accepting any affordability argument at face value.

A related structural problem affects in-hospital diagnostic services. Some funds pay inadequately for in-hospital radiology and pathology services, with the result that patients receive out-of-pocket bills for diagnostic services they had no practical ability to refuse. A patient in hospital does not choose which radiologist reads their imaging or which pathologist processes their specimens. These services are delivered by whoever the hospital contracts with, and the patient discovers the actual financial consequences only when the bill arrives.

Hospitals typically provide a generic disclosure document at admission noting that out-of-pocket costs may apply for diagnostic services and listing which funds do and do not have no-gap arrangements with the contracted provider. This is not informed financial consent in any meaningful sense. The disclosure is generic about the scope of possible cost while the actual cost is unknowable at the point of signing because the clinical decisions about what imaging will be required have not yet been made. The patient cannot meaningfully decline because doing so means refusing the imaging the clinical episode requires. The patient cannot choose a different provider because the diagnostic provider is determined by hospital contract; changing hospitals at the point of admission is not a realistic option.

The pattern is widespread. Large private hospital networks operate with contracted radiology providers, and several of Australia's largest funds have not entered no-gap arrangements with those providers. Patients admitted to those hospitals with those policies, requiring imaging as part of their clinical care, face potential out-of-pocket exposure that may be capped at several hundred dollars per week of admission but for as long as imaging continues to be required.

This is a sharper version of the gap problem identified throughout this submission. Where a treating specialist relationship at least permits patient-specific informed financial consent in advance, in-hospital diagnostic services do not. The fund's discretion to pay inadequately for those services therefore transfers cost to patients in circumstances where consent is structurally impossible.

The committee may also wish to consider whether the trajectory toward managed care described above warrants explicit policy attention before it advances further, rather than after.

End Notes

1. Australian Society of Anaesthetists, fee schedule data 2017 to 2025 (annual publications)
2. Medibank Private, GapCover and No Gap Program billing documentation for anaesthetists
3. Honeysuckle Health Pty Limited, Honeysuckle Health Anaesthetics Network Terms and Conditions, January 2024, available at honeysucklehealth.com.au
4. nib GapSure Anaesthetics network, network description published at nib.com.au
5. No Gap Surgery, program description published at nogapsurgery.com
6. Australian Bureau of Statistics, Consumer Price Index data 2017 to 2025
7. Australian Prudential Regulation Authority, Quarterly Private Health Insurance Membership and Benefits Summary, September 2025, including specialty composition data for medical benefits paid under hospital arrangements, available at apra.gov.au.