March 2024

State of the Health Funds Report

Relating to the financial year 2022–23

Report required by s 20D(c) of the *Ombudsman Act 1976*

COMMONWEALTH OMBUDSMAN

Helping people, improving government

Foreword

I am pleased to present the 19th annual State of the Health Funds Report, relating to the financial year 2022–23. The *Ombudsman Act 1976* requires that I, as the Private Health Insurance Ombudsman (PHIO), publish the report after the end of each financial year to provide comparative information on the performance and service delivery of all health insurers[1] during that financial year.

This report provides only a summary of the information about health insurers that is available on my Office's **privatehealth.gov.au** website, which is Australia's leading independent health insurance website. All 35 health insurers in Australia are required to keep their information on the website accurate and current.

I encourage consumers to visit the site where they can search and compare all health insurance policies available in Australia, including against their existing policy. The website also allows consumers to access other information – such as how many hospitals an insurer has agreements with in their state or local area – that may be relevant to their choice of insurer.

I thank the Australian Prudential Regulation Authority (APRA) for its assistance and advice to my Office in preparing this report. The information included in the report is based on data APRA collects as part of its role to monitor and report on the financial management of health insurers.

Iain Anderson

Commonwealth Ombudsman

[1] For the purposes of this report, "health insurers" refers to "health funds".

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About the data used in this report

The State of the Health Funds report

The State of the Health Funds Report (SOHFR) compares how health funds perform across the following criteria:

- service performance and financial management
- hospital benefits
- medical gap schemes
- general treatment (extras) benefits.

Consumers can use the information in this report to consider insurers' suitability for their circumstances or assess their current insurer's performance relative to others.

The range of indicators included in this report allow consumers to focus on the factors most important to them, noting that not all factors will be of equal value to every individual or family.

More information about specific indicators is provided in the explanations preceding each of the tables in this report.

Open and restricted membership health insurers

Membership of 'open' health insurers is available to everyone.

'Restricted membership' health insurers have certain membership criteria which mean they are not available to all consumers. For example, membership may be restricted to employees of certain companies, occupations or members of particular organisations.

Where applicable, open and restricted membership funds are listed separately in each of the tables in this report.

Data collection

Most data used in this report is collected by the industry regulator, the Australian Prudential Regulatory Authority (APRA). While insurers report to APRA for regulatory purposes, some of the information they provide is useful to consumers and is reproduced in this report. However, it is important to read the text explaining the data in conjunction with the tables.

As funds differ in size, most of the statistical information is presented as percentages or dollar values per membership, for easier comparison. We have not weighted the importance of various indicators, as these are subjective judgements that consumers are better placed to make based on their individual circumstances, preferences and priorities. For the same reason, we have not consolidated or averaged insurers' scores across indicators to provide an overall performance or service delivery score.

The report provides consumers with information about the benefits each insurer paid over the last year. It also includes information about the extent of coverage insurers provided for hospital, medical and general treatment and the differences in each insurer's average policy coverage across Australia.[2] The indicators we used in this report are not intended to represent the full range of factors that consumers should consider when comparing insurers' performance. Rather, they reflect those for which there is reliable data which can reasonably be compared across all insurers.

[2] Consumers can also access this information, broken down by state, under each insurer's performance tab on **privatehealth.gov.au**.

Summary of the year 2022–23

In 2022–23, the Office received 3,429 complaints about private health insurance, a 26.8 per cent increase compared to the number we received in 2021–22. Most complaints were about Australian private health insurers, but we also received complaints about overseas visitor and overseas student health cover providers, health insurance brokers, and healthcare providers.

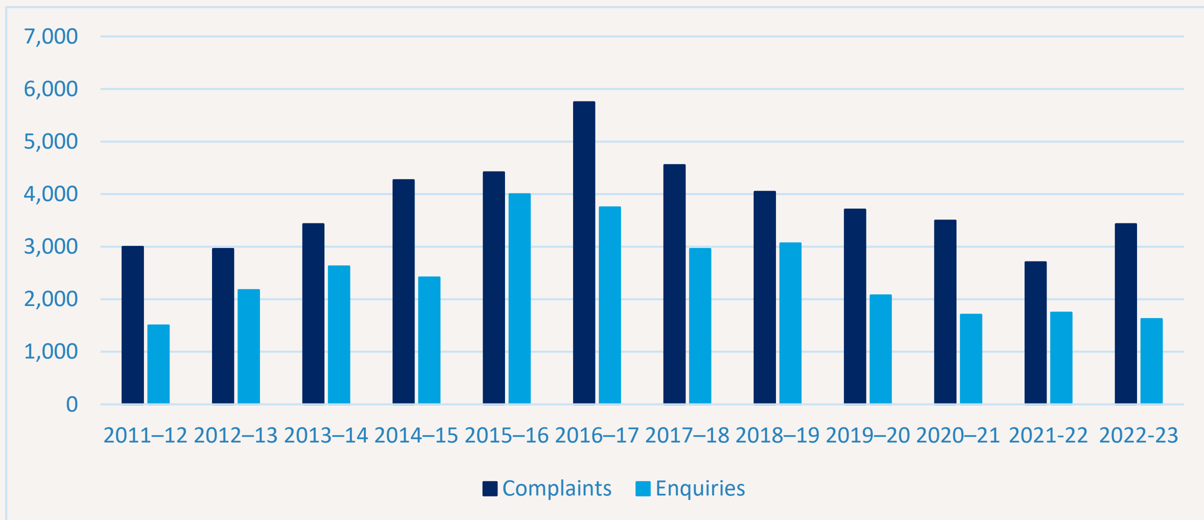
The increase in complaints resulted from several factors including Medibank's data breach and members accessing (and complaining about) health insurance more consistently following lower rates of access during the COVID-19 pandemic.

In October 2022, Medibank detected a data breach in its systems. The personal information of 9.7 million current and former customers was stolen by hackers. The Office received 186 complaints related to the Medibank data breach, a relatively small number given the size of the issue, but it is reasonable to assume that most complaints about the matter were made to the Office of the Australian Information Commissioner (OAIC). The OAIC opened an investigation into the data breach in December 2022 and, at the time of publishing this report, the investigation is ongoing.

The Office received an increase in cancellation complaints in 2022-23 which was largely attributable to complaints about Peoplecare Health Limited (Allianz), an overseas visitor and overseas student health cover insurer. With the end of the pandemic travel restrictions, allowing students and visitors to return to Australia, Allianz received high numbers of cancellation and refund requests resulting in 308 complaints.

In 2022-23, we also received 1,622 private health insurance enquiries. Enquiries are matters we resolve by providing general advice or information, or which involve matters outside our jurisdiction and are recorded separately to complaints (see page 8 for further information).

Figure 1: Total complaints and enquiries by year



Complaints

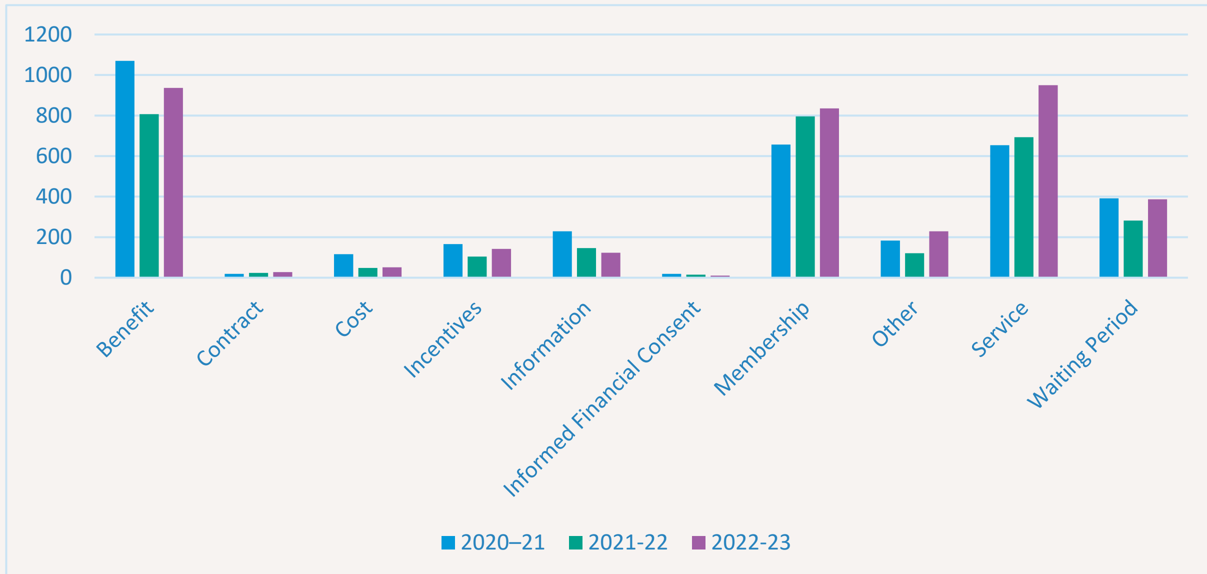
During 2022–23, the most common issues in consumer complaints related to service, benefits, and membership.

When consumers contact us about an insurer's service, it is rarely the sole reason for their complaint. In our experience, they usually flow from another issue which, when combined with poor customer service, inadequate or delayed responses and poor internal escalation processes, cause policy holders to become increasingly dissatisfied.

Complaints about benefits include those about general treatment (extras/ancillary) benefits and unexpected hospital policy exclusions and restrictions, typically about the amount the insurer paid for the service or the time it took to process a claim.

In most instances, complaints about membership relate to membership cancellation. These complaints generally reflect problems and delays in insurers processing requests to cancel memberships and handling associated payments or refunds. In most cases, consumers are transferring from one insurer to another, rather than leaving private health insurance altogether.

Figure 2: Complaint issues over past 3 years



Enquiries

Most enquiries the Office received during 2022–23 were about how private health insurance works and Lifetime Health Cover.

In 2022-23, 29 per cent of enquiries were about general private health insurance issues. Although the Office does not recommend particular insurers or policies, we can provide general information to consumers about what factors they should consider when selecting a policy.

Equally, 29 per cent of enquiries were about Lifetime Health Cover (LHC). LHC is a policy designed to encourage people to take out hospital insurance earlier in life and maintain their cover as they age. It imposes a loading on membership premiums for every year the member is aged over 30 when taking out cover, which is removed once the member reaches 10 years of continuous coverage.

We observed a greater proportion of inquiries in 2022-23 were about Overseas Visitor Health Cover, making up 21 per cent of all enquiries compared to 16 per cent of enquiries in 2021–22. This likely reflects the continued easing of COVID-19 restrictions during the period and the resulting increases in international travel and tourism.

Consumers also contacted our Office to seek:

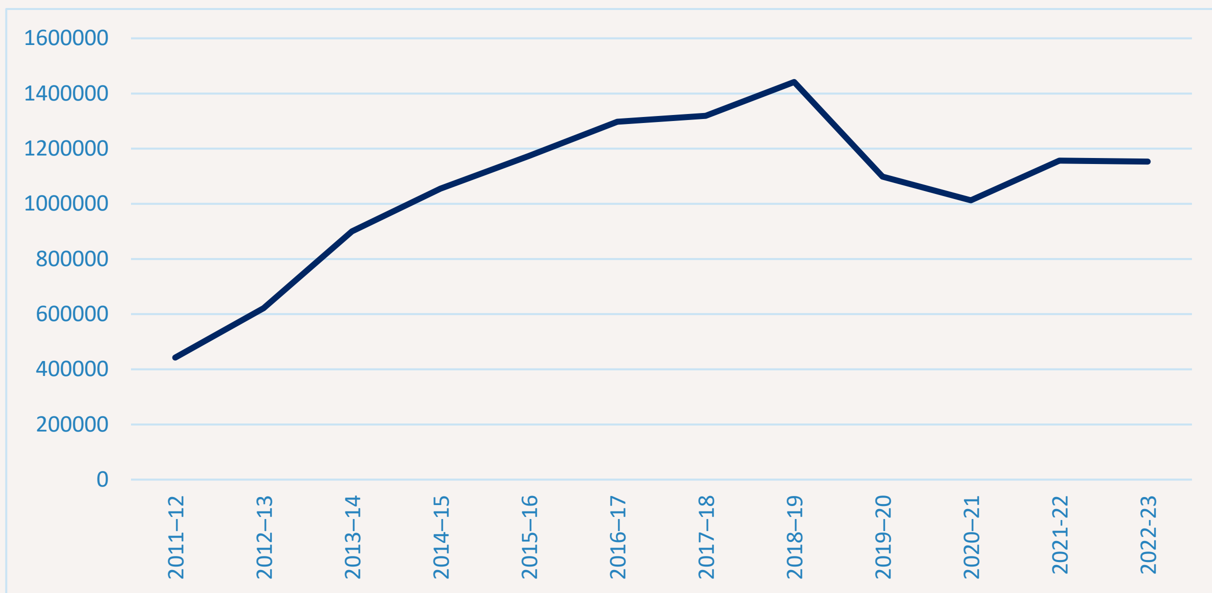
- information about government incentives such as the government rebate and Medicare levy surcharge
- information about health insurance for overseas students studying in Australia

- information about the role of the Private Health Insurance Ombudsman
- general advice about Australia's healthcare system.

Consumer website privatehealth.gov.au

During 2022–23, visits to the website remained steady compared to the previous year, with 1,153,195 visitors compared to 1,156,679 visitors in 2021–22. The website largely relies on organic growth, with most visitors discovering the website through search engines.

Figure 3: privatehealth.gov.au visitors per year



Service Performance and Finances

Member retention

The member retention indicator is used as one measure of the comparative effectiveness of health insurers and their level of member satisfaction. This indicator measures what percentage of members (hospital memberships only) have remained with the insurer for 2 years or more.

This figure is calculated on the total gain or loss of members over the last 2 years (at 30 June 2023), considering consumers who take up membership and leave within that 2 year period. Figures are not adjusted for policies that lapse when a member dies, as these are not reported to APRA.

Most restricted membership insurers rate well on this measure compared to open membership insurers. This may be due to features particular to restricted membership insurers, especially their links with employment.

Ombudsman complaints in context

The number of complaints we receive is generally very small compared to insurer membership.

There are several factors (other than share performance) that can influence the level of complaints we receive about an insurer. These include the information the insurer and the media provide to members about the Ombudsman and the effectiveness of the insurer's own complaint handling process.

Complaints percentage compared to market share percentage

Table 1 shows each insurer's market share (at 30 June 2023) in the market share column. Subsequent columns show the complaints we received about each insurer, as a percentage of the total complaints we received about all insurers. These percentages should be compared with insurers' market share figures. Where an insurer's share of complaints was higher than its market share, this indicates that members of that insurer were more likely to complain than those of other similar sized insurers.

The table also indicates the percentage of complaints we received about each insurer. Note that these figures exclude complaints the Office received about overseas visitor and overseas student health cover providers, brokers, and healthcare providers.

All complaints takes account of all complaints the Office received about the insurer. It includes complaints we investigated as well as complaints we finalised without the need for investigation. It excludes complaints about overseas visitor and overseas student health cover.

Complaints investigated[3] reflects complaints about the insurer that required a higher level of intervention by the Office, as a percentage of all complaints we investigated about all insurers. We can finalise most complaints to the Office by providing information to the complainant or referring the matter to insurer staff to resolve. Where insurer staff do not resolve a complaint to a member's satisfaction, we will investigate, so the rating for *complaints investigated* is an indicator of the effectiveness of an insurer's internal complaint handling arrangements.

Finances and costs

All health insurers are required to meet financial management standards, to ensure members' contributions are protected. Generally, insurers aim to set premium levels so their income from contributions covers the expected cost of benefits plus the insurer's administration costs.

The regulation of health insurer finances

The *Private Health Insurance Act 2007* (Cth) (the Act) specifies the standards that insurers must meet to ensure they remain financially sound and sets out financial management and reporting requirements for all insurers.

APRA produces an annual publication with financial and operational statistics for all insurers for each financial year.[4] Information included in the **Benefits as a Percentage of Contributions** and **Management Expenses** fields is drawn from data APRA collect.

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[3] Complaints investigated were referred to as “disputes” in previous versions of this report.
[4] The ‘Operations of the Private Health Insurers’ report is available on the APRA website: apra.gov.au

Benefits as a percentage of contributions

This column shows the percentage of total contributions the insurer received that it returned to contributors in benefits. Insurers will generally aim to set premium levels so that contribution income covers the expected costs of benefits plus the insurer's administration costs.

Management expenses

Management expenses are the insurer's administration costs. They include items such as staff salaries, operating overheads, and marketing costs.

As a percentage of contribution income: This figure is regarded as a key measure of insurer efficiency. In this table, management expenses are shown as a proportion of total insurer contributions.

Per average policy: A comparison of the relative amount each insurer spends on administration costs. This figure shows management expenses per policy, noting a policy may cover an individual, a couple or a family.

Table 1: Service performance and finances

Insurer name (abbreviated)	Member retention (hospital cover)[5]	Market share	All complaints %	Complaints investigated %	Benefits as % of contributions	Management expenses as % of contribution income	Management expenses per average policy
Open membership insurers							
AIA Health	76.1%	0.4%	1.3%	4.9%	83.2%	12.3%	$435
Australian Unity	79.0%	2.2%	4.7%	1.6%	70.0%	13.8%	$570
BUPA	87.7%	24.9%	23.7%	24.7%	80.9%	10.8%	$406
CBHS Corporate	71.1%	<0.1%	0.1%	0.0%	84.0%	27.3%	$1,187
CDH	88.4%	<0.1%	0.0%	0.0%	70.9%	24.5%	$1,214
CUA Health[6]	n/a	n/a	0.3%	0.0%	n/a	n/a	n/a
GMHBA	78.9%	2.2%	1.9%	2.7%	78.9%	11.9%	$453
HBF	89.9%	7.7%	3.7%	7.7%	87.9%	16.7%	$586
HCF	88.2%	12.5%	13.5%	10.4%	87.7%	11.5%	$472
HCI	88.2%	0.1%	0.1%	0.0%	74.7%	18.4%	$821
Health Partners	90.2%	0.7%	0.7%	0.5%	81.9%	10.0%	$419
HIF	75.9%	0.7%	0.9%	3.3%	78.8%	15.2%	$540
Latrobe	77.8%	0.7%	0.7%	0.0%	79.0%	19.6%	$845
MDHF	91.5%	0.3%	0.1%	0.5%	82.4%	9.3%	$373
Medibank	86.9%	27.1%	29.9%	19.2%	83.4%	7.4%	$263
NIB	82.7%	9.6%	10.1%	11.0%	79.0%	12.3%	$438
Onemedifund	93.8%	0.1%	0.0%	0.0%	73.7%	9.8%	$629
Peoplecare	85.9%	0.5%	0.5%	0.5%	83.3%	13.6%	$629
Phoenix	85.0%	0.2%	0.1%	0.0%	77.7%	10.0%	$484
QCH	87.6%	0.4%	0.1%	0.0%	79.8%	10.8%	$531
St Lukes	89.4%	0.6%	0.5%	1.6%	83.6%	12.7%	$595
Transport Health[7]	n/a	n/a	0.2%	0.0%	79.5%	16.1%	$527
Westfund	87.1%	0.9%	0.5%	0.5%	83.3%	12.8%	$548

[5] The total gain or loss of members over the last two years, which takes into account consumers who take up membership and leave within that two year period.
[6] CUA merged with HBF, with all CUA policies transferred to HBF effective 1 January 2023, so retention and market share are not applicable. CUA has also been granted a reporting exemption for annual return.
[7] Transport merged with HCF, with all Transport policies transferred to HCF effective 1 January 2023, so retention and market share are not applicable.

Table 1 (continued): Service performance and finances

Insurer name (abbreviated)	Member retention (hospital cover)[8]	Market share	All complaints %	Complaints investigated %	Benefits as % of contributions	Management expenses as % of contribution income	Management expenses per average policy
Restricted membership insurers							
ACA	91.4%	0.1%	0.0%	0.0%	75.6%	11.7%	$686
CBHS	92.4%	1.5%	1.5%	2.2%	84.2%	10.7%	$509
Defence Health	91.0%	2.0%	1.5%	2.2%	76.4%	12.0%	$552
Doctors' Health	90.2%	0.5%	0.2%	0.0%	80.4%	13.1%	$605
Navy	89.4%	0.4%	0.2%	0.5%	83.4%	10.4%	$469
Police Health	91.2%	0.5%	0.4%	0.5%	86.9%	7.2%	$438
Reserve Bank	91.3%	<0.1%	0.0%	0.5%	74.9%	15.5%	$1,202
Teachers Health	96.8%	2.6%	2.3%	4.4%	86.0%	9.3%	$449
TUH	90.6%	0.6%	0.1%	0.0%	82.6%	9.3%	$474

[8] The total gain or loss of members over the last two years, which takes into account consumers who take up membership and leave within that two year period.

Average policy coverage per insurer

Table 2 summarises the average coverage of each insurer's policies across Australia. More information about each health insurer's benefits, including benefits by state, is available on **privatehealth.gov.au**. This table includes:

- the proportion of private hospital charges covered on average
- the proportion of medical services for which a gap is not payable by the patient after accounting for insurer benefits, schemes and agreements
- the proportion of medical services for which either a gap is not payable (as above) or which fall under a 'known gap scheme', where the insurer pays an additional benefit on the understanding that any fee charged by the medical provider is lower than the limit set by the insurer (thereby bridging the gap that would otherwise apply for the consumer), and
- the average proportion of service charges each insurer covers per state for all their policies and services associated with general treatment (often known as 'extras').

The effectiveness of insurers' medical gap schemes can differ between states, so state-based information is also published on a per-insurer basis under each insurer's 'Performance' tab on **privatehealth.gov.au**.

Most differences are due to doctors' fees, which can vary significantly between states, and between regional areas and capital cities. In some states, insurers can cover gaps more effectively because doctors in that location charge less than the national average. Also, where a doctor's fee for an in-hospital service is at or below the Medicare Benefits Schedule fee, there will be no gap to the member.

If a health insurer's percentage of services with no gap is higher than that of an insurer in another state, it does not necessarily mean the insurer's scheme is more effective. State-based differences may also be a factor.

Private hospital treatment

A higher percentage under the first column of Table 2 (relating to hospital related charges) indicates that, on average, the insurer's members are covered for a higher proportion of private hospital charges.

The percentages indicated in this table do not reflect any one policy but are an average of all policies the insurer offered.

Hospital policies provide benefits towards the following costs if you elect to be a private patient in a private or public hospital:

- hospital fees for accommodation, operating theatre charges and other charges raised by the hospital
- the costs of drugs or prostheses required for hospital treatment
- fees charged by doctors (surgeons, anaesthetists, pathologists, etc.) for in-hospital treatment.

Most insurers offer a range of different policies which provide hospital cover. These policies may differ in the range of treatments they cover, the extent to which they cover those treatments, the level of excess or co-payment the member may need to pay for a hospital admission, and the price and discounts available to them.

This column indicates the proportion of total charges for treatment of private patients that each insurer's benefits cover. This includes charges for hospital accommodation, theatre costs, prostheses and specialist fees (not including the Medicare benefit), excesses or co-payments and associated benefits.

Hospital related charges covered (per cent) is calculated as: *(Hospital benefits paid by insurer / Fees excluding Medicare benefit) * 100.*

'Fees' is the total amount the patient would have to pay to the provider(s) in the absence of any private health insurance, inclusive of hospital, medical and prostheses fees. This amount excludes the Medicare benefit. The difference between fees charged and benefits paid is the amount that the patient must pay (out of pocket).

The **privatehealth.gov.au** website provides information about all private health insurance policies available in Australia, including benefits, prices and agreement hospitals for each health insurer.

Medical gap schemes

'Medical gap schemes' are intended to reduce patients' out of pocket costs for in-hospital medical services, such as fees from surgeons, anaesthetists, assistant surgeons, pathology and diagnostic services.

If a service is 'no gap', it means the patient did not incur any costs, as the full cost was covered by Medicare and the health fund. If a health insurer has a higher percentage of services covered at no gap than other insurers, it indicates the insurer has a more effective gap scheme in that state. This means it is more likely that a medical service can be provided at no cost to the consumer, but it does not guarantee that a particular doctor will choose to use the insurer's gap scheme.

Insurer gap schemes and agreements

Doctors are free to decide whether to use a particular insurer's gap cover arrangements for each patient. Factors that can affect doctors' acceptance of a scheme include:

- whether the insurer has a substantial share of the health insurance market in a particular state or region
- the level of insurer benefits paid under the gap arrangements (compared with the doctor's desired fee)
- the design of the insurer's gap cover arrangements including any administrative burden for the doctor.

Comparing different medical gap schemes

The second and third columns of Table 2 consider all the insurer's policies. The information in the tables does not reflect any individual policy the insurer offers but is an average across the insurer's total membership.

Percentage of services with no gaps – this column indicates the proportion of medical services for which the patient is not required to pay a gap after accounting for insurer benefits, schemes and agreements.

Percentage of services with no gap or where known gap payment made – this column includes both the percentage of no gap services (as above) as well as what are called 'known gap' services. Known gap schemes are an arrangement where the insurer pays an additional benefit on the understanding that any fee charged by the medical provider is lower than the limit set by the insurer. For example, the insurer may limit the provider to charging a gap fee to the consumer of no more than $300.

General treatment (extras)

General treatment policies, also known as 'ancillary' or 'extras' provide benefits towards a range of out-of-hospital health services.

The final column of Table 2 indicates the average proportion of total charges, associated with general treatment services, which is covered by each insurer's benefits. This is an average of outcomes across each insurer's general treatment policies and services. Higher cost policies will generally cover a greater proportion of charges than indicated by this average, while cheaper policies may cover less.

General treatment policies provide benefits towards a range of health-related services not provided by a doctor including, but not limited to:

- dental fees and charges
- optometry – cost of glasses and lenses
- physiotherapy, chiropractic services and other therapies including natural and complementary therapies
- prescribed medicines not covered by the Pharmaceutical Benefits Scheme.

Table 2: Australia-wide average policy coverage per insurer

Insurer name (abbreviated)	% Hospital related charges covered[9]	% Medical services with no gap	% Medical services with no gap or known gap payment made	% General treatment (extras) Charges covered
Open membership insurers				
AIA Health	80.2%	84.3%	95.2%	45.8%
Australian Unity	88.7%	91.4%	97.8%	51.7%
BUPA	90.1%	91.1%	98.1%	49.6%
CBHS Corporate	84.8%	82.1%	93.1%	48.7%
CDH	94.4%	83.5%	96.1%	34.6%
CUA Health	90.2%	92.2%	98.1%	45.7%
GMHBA	89.1%	86.7%	95.7%	47.5%
HBF	93.7%	92.5%	99.6%	55.5%
HCF	89.1%	86.7%	97.2%	50.3%
HCI	91.9%	91.5%	97.9%	46.6%
Health Partners	93.2%	91.0%	99.4%	56.8%
HIF	89.7%	89.6%	97.8%	46.3%
Latrobe	89.8%	75.3%	99.5%	40.2%
MDHF	91.4%	81.2%	99.9%	53.5%
Medibank	90.0%	83.8%	96.5%	52.6%
NIB	85.9%	91.7%	92.3%	57.5%
Onemedifund	92.5%	89.6%	97.7%	48.6%
Peoplecare	90.7%	90.9%	98.0%	44.3%
Phoenix	90.5%	91.4%	98.3%	54.1%
QCH	86.8%	89.3%	97.3%	47.4%
St Lukes	91.9%	88.9%	98.3%	56.3%
Transport Health	92.4%	85.2%	92.9%	46.9%
Westfund	90.7%	90.3%	97.8%	44.9%
Restricted membership insurers				
ACA	93.8%	92.8%	97.9%	56.5%
CBHS	90.6%	85.3%	97.5%	46.2%
Defence Health	89.6%	89.7%	97.8%	41.7%
Doctors' Health	90.8%	93.0%	97.8%	53.2%
Navy	89.8%	90.0%	97.6%	48.3%
Police Health	92.4%	87.3%	97.7%	65.8%
Reserve Bank	92.4%	90.3%	97.4%	69.6%
Teachers Health	90.5%	90.3%	97.6%	44.6%
TUH	90.2%	91.8%	98.3%	51.7%
Industry average	89.9%	88.3%	97.2%	51.1%

[9] Includes charges for hospital accommodation, theatre costs, prostheses and specialist fees (not including the Medicare benefit) and associated benefits (after any excesses and co-payments are deducted).

Health insurer listing

Table 3 lists all Australian registered health insurers. The 'open' membership insurers provide policies to the general public. The 'restricted' insurers provide policies through specific employment groups, professional associations or unions.

During 2022–23, CUA Health merged with HBF and Transport Health merged with HCF. For this reason, some of the fields in this report relating to those insurers are recorded as ‘not applicable’.

Some insurers use several different brand names or have used brand names in the recent past. These are listed under ‘Other brand names’.

Table 3: Health insurer listing

Abbreviation	Full name or other names	Other brand names
Open membership health insurers		
AIA Health	AIA Health Insurance, MyOwn Health Insurance	
Australian Unity	Australian Unity Health Ltd	
BUPA	Bupa HI Pty Ltd	NRMA Health
CBHS Corporate	CBHS Corporate Health Pty Ltd	
CDH	CDH – Hunter Health Insurance	
CUA Health	CUA Health Ltd	
GMHBA	GMHBA Ltd, Frank	Budget Direct, Health.com.au
HBF	HBF Health Ltd	GMF, Healthguard
HCF	Hospitals Contribution Fund of Australia	Manchester Unity, Railway and Transport (RT) Health
HCI	Health Care Insurance Ltd	
Health Partners	Health Partners Ltd	
HIF	Health Insurance Fund of Australia Ltd	
Latrobe	Latrobe Health Services	
MDHF	Mildura District Hospital Fund Limited	
Medibank	Medibank Private Ltd, Australian Health Management	Kogan
NIB	NIB Health Funds Ltd, Qantas Assure, APIA	AAMI, GU Corporate Health, Suncorp
Onemedifund	National Health Benefits Australia Pty Ltd	
Peoplecare	Peoplecare Health Insurance Limited	
Phoenix	Phoenix Health Fund Ltd	iSelf
QCH	Queensland Country Health Fund Ltd	Territory Health
St Lukes	St. Lukes Health	Astute Simplicity Health
Transport Health	Transport Health Pty Ltd	
Westfund	Westfund Limited	
Restricted membership health insurers		
ACA	ACA Health Benefits Fund	
CBHS	CBHS Health Fund Ltd	
Defence Health	Defence Health Ltd	
Doctors' Health	The Doctors' Health Fund	
Navy	Navy Health Ltd	
Police Health	Police Health Limited, Emergency Services Health	
Reserve Bank	Reserve Bank Health Society Ltd	
Teachers Health	Teachers Federation Health Ltd	Nurses and Midwives Health, UniHealth
TUH	Teachers' Union Health Fund	Union Health

Using this report to compare insurers

Please note:

- Nothing in this report should be taken as this Office recommending any health insurer or health insurance policy.
- No single indicator should be used as an indicator of an insurer's overall performance.
- The information used in this report to compare health insurers is based on data collected for regulatory purposes. This information was the most appropriate, independent and reliable data available at 1 December 2023.
- This report may help consumers decide which health insurers to consider but will not indicate which policy/ies to purchase. Most insurers offer more expensive policies that can be expected to provide better than average benefits, as well as cheaper policies that provide lower benefits.

Where to find more information about selecting a policy

The Ombudsman's consumer website **privatehealth.gov.au** includes advice about what factors to consider and what questions to ask when selecting a policy. It also includes information about government incentives relating to hospital cover such as the 'Medicare Levy Surcharge Exemption' and 'Lifetime Health Cover'.

This report does not include detailed information on price and benefits for health insurance policies. Information on specific policies is available from **privatehealth.gov.au**, where you can search for and compare information about every health insurer and policy in Australia.

For more information visit ombudsman.gov.au or call 1300 362 072