FAQ for Access Gap Cover (AGC) Medical Providers AGC Benefits Review and Indexation – 1 July 2024

1. What is changing?

- From 1 July 2024, the fees in all 8 (state and territory based) AGC fee schedules have been reviewed.
- When compared to the previous AGC schedules, some fees have increased, some have decreased and some fees have stayed the same.
- Medicare indexation has been added (to the portion which is the Medicare Benefit Schedule (MBS) fee) on all AGC schedules.
- AHSA indexation has been added (to the portion above the MBS fee) on targeted specialties by state and territory.

2. What is the impact of the AGC Review?

- The benefits for many surgical specialties have increased, especially where we felt our benefits were too low.
- Some benefits have decreased when compared to the previous schedules. Decreases to most benefits have only occurred where we believe we are above the industry norm and where it should not have too much impact on patient gaps.
- Also, in some instances, where the current rate is significantly higher than other states and territories, some medical providers may see a reduction in AGC rates.
- These changes will not result in overall cost savings for the funds. They are designed to better reflect the needs of the members who use it.
- No funding has been removed from AGC – it has been redistributed across the schedules to be non-inflationary.
- Our approach aimed to minimise the overall impacts on medical providers and patients.

3. Do I need to do anything?

- No, you can continue to use AGC as you do now. It is your choice.
- We encourage you to use AGC for all eligible members however, you can still opt-out on an episode-by-episode basis. Again, it is your choice.

4. What if I have already provided a quote to my patient?

- Please make sure that your patients are informed if you wish to amend any quote you have already provided, to ensure financial consent.

5. Why have the AGC benefits been reviewed?

- We need to keep AGC contemporary and ensure the benefits remain relevant and up to date.*
- To address some anomalies within some specialties.
- For the vast majority, to ensure that each specialty within the state or territory-based schedule has the same benefit above MBS fee across the whole specialty. This means that when new items are introduced, new benefits are consistent across the specialty in that state or territory.

> ** Special Note*
>
> *It is so important that you put the whole charge on the claim to the fund (including any patient co-payment).* ***If you send a separate gap account to your patient without informing the fund or Medicare, we will never know the true charge and therefore medical benefits will never be reviewed properly.***
>
> *We want doctors to keep using AGC, so we need to ensure the benefits are reasonable, especially in relation to your charges.*
>
> *We know that our members want more value from their private health insurance. We understand that out-of-pocket costs are difficult to bear. Part of this review was looking at where we could potentially decrease out-of-pocket costs on as many services as possible.*

6. Will AGC be indexed in addition to the benefits review and at what level?

- Medicare indexation has been added to the portion which is the Medicare Benefit Schedule (MBS) fee, on all AGC schedules.
- AHSA indexation has been added to the portion above the MBS fee, on targeted specialties by state and territory.
- The level of AHSA indexation varies between 0 and 3.5%, depending on the specialty and state. Where the AGC benefit is already considered high, there has been no AHSA indexation to the portion of the AGC fee above the MBS fee. This will be monitored on a yearly basis.

7. What happens if I have an admission booked on or after 1 July 2024?

- For pre-booked admissions on or after 1 July 2024 the new medical gap scheme benefits will apply.
- If the patient admission runs over 1 July 2024, the date of service will determine which rate is used, i.e., use the old rates for services prior to 1 July 2024 and use the new rates for services on or after 1 July 2024.
- Please make sure that members are informed if you wish to amend any quote you have already provided, to ensure financial consent.

8. Why have some fees decreased?

- Some benefits have increased in the hope that it will lessen patient gaps. To balance the increase, some other benefits have decreased.
- Some benefits decreased to address anomalies within specialties in each of the state schedules.
- Some benefits have decreased where the current rate is significantly higher than the industry norm.
- The review to AGC has been cost neutral overall to ensure private health insurance remains viable and competitive.

9. Why isn't AGC national? Why do you have individual state schedules?

- AHSA administers AGC for over 20 private health funds, many of which are located regionally and/or predominantly within one state.
- As doctor's charges can differ greatly from state to state (and even regionally), many AHSA funds would be impacted greatly to move to a national schedule.
- AHSA will work towards a national schedule but it may take a few years to get there and only if we feel it is warranted.
- Where possible, inconsistencies between procedures/specialties across states were reviewed.

10. Has anything else changed, other than some of the AGC fees?

- No - the Billing Guide and the Terms and Conditions have not changed.
- There have been no changes made to the AGC rules, including the allowable co-payment.
- To obtain a current copy of these documents, click on 'Billing Guide & Terms and Conditions'.

11. Why haven't you increased the allowable patient co-payment?

- The AGC allowable co-payment was reviewed on 1 July 2020 where for most episodes (those with a single MBS item), it increased from $400 to $500 per provider per episode.

12. What is the most I can charge my patient as a gap?

- This has not changed.
- Each individual medical provider in the admitted episode of care can choose to charge their patient a maximum out-of-pocket cost of up to $500 for MBS rebateable items only.
- Obstetricians can choose to charge their patient a maximum out-of-pocket cost of up to $800 per episode for MBS items that relate to 'Management of Labour and Delivery'.
- Refer to the 'Billing Guide & Terms and Conditions' for a more detailed explanation and other conditions.

13. Where can I obtain a copy of the current AGC schedule?

- To obtain a current copy of the schedule, go to Schedules on the AHSA website. (Please note that salaried doctors at public hospitals will be reimbursed at MBS fee only.)

14. Who can I talk to at AHSA about this change?

- Please do not hesitate to email access@ahsa.com.au or call the Access Gap Cover Hotline on 1800 664 277 or should you have any queries.
- Please note: Any questions relating to the patient's private health insurance product, coverage or claims should be directed to individual funds. Please refer to the Participating Fund Contact List - AHSA