Guide to Choosing Health Insurance Wisely

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If you've done a cursory glance of health insurance in Australia then you'll see some common options. Almost all the providers offer both hospital and hospital + extras cover as standard options. Most range from budget through to premium cover and then there are further options for single, couples and families. You'll often be guided on websites to a limited number of products based on a few questions, then required to make a decision – so what should you look out for at this stage?

Taking out health insurance has tax benefits

If you are among the Australians who earn over $90,000 pa then without private health cover you will pay an additional tax of at least 1% of your gross income. The tax increases with your salary. For singles it increases to 1.25% for incomes over $105,000 and then to 1.5% for incomes over $140,000; less for families. See more at privatehealth.gov.au/IncentiveSurcharges

Be wary of the advertisements from insurers that suggest you should acquire health insurance prior to 30 June to avoid tax. The truth is that the tax benefit is only pro-rated, so if you acquire health insurance on 29 June just before the end of the financial year, you'll still be liable to pay the surcharge for the 364 days of the year when you didn't have health insurance. However, some rebate is better than no rebate in most cases.

The rebate the Government provides (ie the amount the Government pay for you) also reduces with your income. See more at privatehealth.gov.au/InsuranceRebate

The rebate and surcharge levels applicable from 1 April 2017 to 31 March 2018* are:

Income per annum				
Singles	Under $90k	$90-105k	$105-140k	$140,000+
Families	Under $180k	$180-210k	$210-280k	$280,000+
Rebate				
	Base Tier	Tier 1	Tier 2	Tier 3
< age 65	25.415%	16.943%	8.471%	0%
Age 65-69	29.651%	21.180%	12.707%	0%
Age 70+	33.887%	25.415%	16.943%	0%
Medicare Levy Surcharge				
All ages	0.0%	1.0%	1.25%	1.5%

Single parents and couples (including de facto couples) are subject to family tiers. For families with children, the thresholds are increased by $1,500 for each child after the first.

*The income thresholds are indexed and will remain the same to 30 June 2021. The Department of Health published theRebates applicable for 1 April 2018 to 31 March 2019.

How to save money by buying (or not buying) health insurance

Given the tax disincentive, it's usually more cost effective to have health insurance for many income earners over $90,000 than not provided you are claiming for a handful of basic services every year. It may still be more cost effective to not have health insurance if you are only looking at the cost, that is provided you never need to claim on it. For example, the 1% surcharge on a $90,000 salary is $900, while a basic health insurance package could be as little as $30 a week, which is $1,560 a year. A single day in a hospital can be anywhere from several hundred to several thousand dollars depending on how much can be claimed through Medicare, so if you use your health insurance then it's likely you'll end up ahead financially.

Increases in health insurance premiums happen once a year at the start of April. You can avoid the increase by paying a whole year in advance prior to this date. That said, you just delay the inevitable increase you'll have to pay the following year if you choose to continue.

Importantly, to make the most of your cover, remember to claim.

How to avoid the Lifetime Health Cover loading

If you're under 30 then the Lifetime Health Cover loading doesn't apply. However, once you are 30, for every year over this age you will pay an additional 2% loading on top of the premium you pay for health insurance for every year.

If you are newly arrived in Australia or are a citizen returning from a long period overseas, then there is some leeway. You are also permitted small gaps in your cover to allow for switching between funds but this cannot total more than 1,094 days.

The maximum loading is 70% and if you are prepared to pay the loading for 10 years, then after that it returns to 0%. If you are looking to save money, then avoiding the lifetime health cover loading is a good move.

How to avoid waiting periods when you switch insurers

When you first acquire private health insurance you'll have to sit a waiting period before you can make claims. Some insurers will allow you to start claiming straight away on certain things but not all. The government sets maximum waiting periods but there is no minimum. The maximum waiting period for hospital cover is two months with the following exceptions:

- 12 months for pre-existing conditions,
- 12 months for obstetrics (pregnancy)
- two months for psychiatric care, rehabilitation or palliative care, even for a pre-existing condition.

If you switch from one insurer to another without a break in cover, **you do not** need to re-serve hospital waiting periods you have previously completed. However, if you're upgrading your hospital cover, you must serve a waiting periods for any new covers you receive. For example, if you move from a plan that excludes pregnancy to a plan that includes it, then you'd have to serve a12-month waiting period before you could claim pregnancy related costs.

There is no legislative limit for waiting periods for extras cover – so you need to read the policy carefully to find out if there is a waiting period that applies for treatment such as physiotherapy. Typical waiting periods that may apply include:

- Two months for benefits for general dental services and physiotherapy
- Six months for benefits for optical items (glasses or contact lenses)
- 12 months for benefits for major dental procedures such as crowns or bridges
- One, two or three years for some high cost procedures such as orthodontics.

How does no-gap cover affect me? (also known as out-of-pocket expenses)

When you see a GP, other specialist or even a practitioner within a hospital you are billed accordingly. Of the amount you are billed, Medicare will pay a portion on your behalf, in many circumstances, and you must pay the balance, which is known as the gap. If you have health insurance with no-gap cover, then your health insurer will pay the gap for you, or at least a portion.

Be aware that unless your health insurer has an arrangement with the service provider, then you will not receive the gap-cover. It is advisable to call and speak with your health insurer prior to a procedure to find out if you'll be able to be covered for the gap. You may have to consider changing providers to get a bigger refund.

Things you can anticipate to get the most out of your cover

You need to think ahead a little with health insurance to maximise its benefits. Insurers are highly likely to use the maximum 12-month waiting period for obstetrics/pregnancy care, so if you are planning a family then switching to a plan that covers this early is a good idea. Here's some of the costly things you can anticipate that may affect you or your family hence you can upgrade your cover early:

- Pregnancy (up to about age 45)
- Wisdom teeth removal (ages 25-35 approximately)

- Braces or other dental for your children
- Hip replacement (for people approaching age 55+)
- Knee surgery (especially for athletes)
- Cataract surgery (ie age-related decline in eyesight especially in people age 40+)
- Any hereditary conditions you may be at risk of (eg Huntington's disease which typically shows itself between ages 30-40)

You should also consider more common costs including:

- Regular dental checkups
- Buying a new pair of glasses (especially if your lens prescription varies)

Upgrading cover 12 months in advance will give you the most protection given the longest maximum waiting period on hospital cover is 12 months, however, there is no legislative maximum on extras, which can be up to 6 years in some cases.

Find out what your excess and co-payments are up front

Both an excess and a co-payment are ways insurers recoup costs in order to keep premiums low. In many cases, when you first buy health insurance you will have the option of an excess, potentially of a varying amount and/or a co-payment of a varying amount that can lower/raise the cost of your premium.

When you make a claim on your health insurance for something as simple as an appointment with the physio, it's unlikely you'll have to pay an excess. These days, you generally swipe your card, find out how much off the bill (if anything) you receive, then pay the balance. However, if you are admitted to hospital you may have to pay an excess to make any claim against the costs for the admission and the treatment you receive. Each day you are in the hospital, you may have to make a co-payment towards treatment for every day you are in hospital. More simply put:

- An excess is a set amount of money you pay upfront towards hospital treatment. You must pay this each time you are admitted to hospital at the time of your claim.
- A co-payment is the amount of money you agree to pay for each day that you are in hospital, up to an agreed amount.

A typical excess is $500, while a co-payment may be $100 a day.

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