Australian Government
Private Health Insurance Ombudsman

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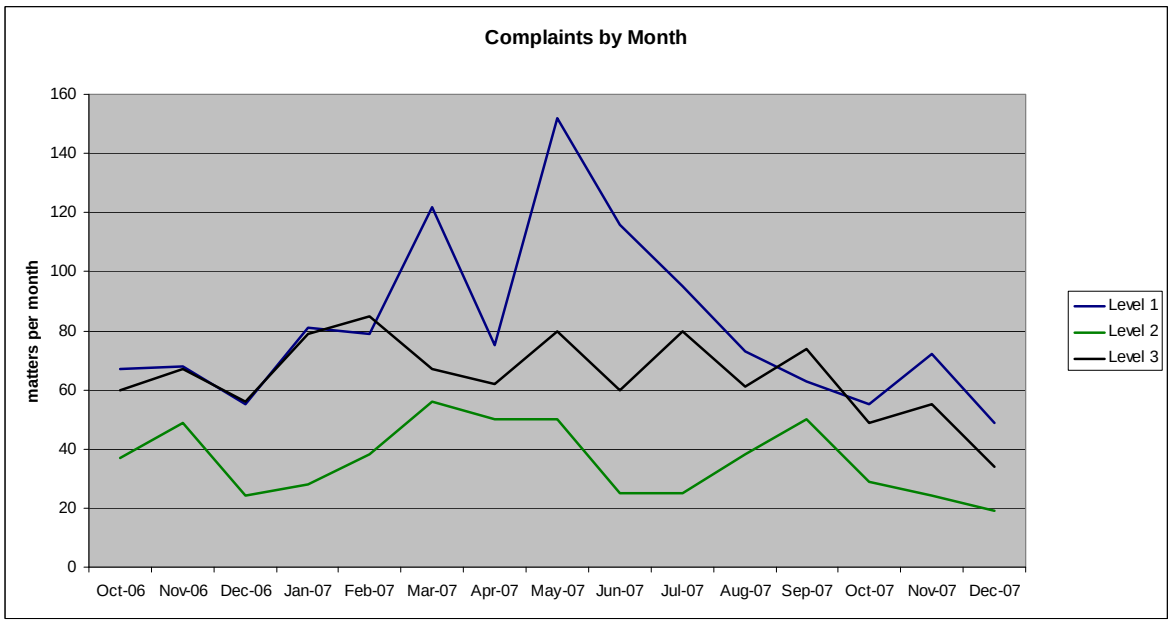
Quarterly Bulletin 45

(1 October to 31 December 2007)

PHIO received 425 complaints about health insurers this quarter. This was a decrease of 22% on the previous quarter and a decrease of 7% compared to the same quarter last year. Of total complaints about health insurers, 144 were Level-3 complaints, which represents a 31% decrease on the previous quarter and an 18% decrease on the same period last year.



Access by Overseas Visitors to Pharmaceutical Drugs

Many health insurance policies for overseas visitors provide only limited benefits for pharmaceutical drugs; usually only a few hundred dollars a year.

The Commonwealth Department of Health & Ageing's PHI Circular 34/07 dated 13th June 2007 advised that the Australian Healthcare Agreements had been amended to allow public hospitals to charge ineligible patients for pharmaceuticals they receive during their treatment. This means that overseas visitors attending public hospitals may incur out of pocket costs for pharmaceuticals.

The changes are likely to have the most significant impact on people who are visiting the country for longer stays and people who have moved to Australia on retirement visas. The terms of the retirement visa specifically exclude holders from access to subsidised pharmaceuticals under the Pharmaceutical Benefits Scheme (PBS), even if they come from countries that have reciprocal agreements with Australia. Retirees live in Australia permanently and therefore rely on access to the Australian healthcare system if they need treatment.

With limited cover for pharmaceuticals under overseas visitor covers and no access to subsidised pharmaceuticals under the PBS, retirees needing treatment are likely to encounter out of pocket costs for pharmaceuticals. In particular, the cost of unsubsidised pharmaceuticals used in oncology (cancer) treatment are substantial.

It is strongly recommended that insurers selling overseas visitor cover review any wording in their brochures which suggests that pharmaceuticals provided to overseas visitors in public hospitals will not be charged to the patient.

In addition, where the cover provides low (ie less than $1000 per annum) or no cover for pharmaceuticals, insurers should ensure their literature makes people purchasing the cover aware that they may face significant out of pocket costs if they need treatment with pharmaceuticals, particularly oncology (cancer) treatment.

The PHIO recently sought an opinion from the ACCC in relation to information in health insurer brochures alerting members to these potentially significant costs.

The ACCC advised that its role is not to prescribe to businesses about how to word their advertising. Nevertheless it advised that it would be best practice for consumer information about visitors cover to contain a specific section under a separate heading that details policy holders' inability to claim under the PBS. This would help ensure consumers are clearly aware of the issue.

PHIO is happy to assist with the drafting of suitable wording and enquiries about this aspect can be e-mailed to sgavel@phio.org.au.

Informing Members about Broader Health Cover Benefits

The PHIO has received its first complaint about benefits for broader health cover. The member suffered from a chronic condition, requiring regular hospital treatment. With the introduction of broader health, the member was hoping she would be able to receive benefits for having her regular treatment provided in her home, rather than having to go to hospital. Her current insurer did not provide this option, so she shopped around to see if she could find an insurer that would enable her to have her treatment at home.

As a long term member and experienced user of the health system, the member rang one insurer to enquire about its new broader health care initiatives. After two lengthy conversations with call centre staff, she was satisfied the insurer's chronic disease management program would meet her needs and transferred her membership to the insurer. As soon as she needed to have her first treatment at home she encountered difficulties and shortly afterwards she received a letter from her new insurer advising her that she did not meet their criteria for their home care program.

PHIO negotiated a remedy for the complainant, on the grounds that she had been misinformed by the insurer's staff and had transferred membership based on that misinformation. PHIO's investigation revealed that insurer staff had only limited knowledge of the insurer's broader health initiatives, which led to the member receiving incorrect information, even though she asked detailed questions relating to her specific situation. This complaint is a timely reminder to insurers to ensure call centre and other staff are aware of new initiatives as they come in and to ensure staff members know where to access accurate information about the details of these initiatives when consumers contact them.

Detrimental Changes to Health Insurance Products

A number of recent complaints and advice from some insurers of planned closures of products in coming months has raised the issue of communicating detrimental rule changes and providing transitional arrangements for members.

The Office has in the past issued the following advice to insurers in relation to detrimental rules changes:

1. Significant detrimental changes to hospital benefits

- Removal of benefits or restriction to default benefits for any identified condition/treatment
- Addition of excesses, co-payments etc
- Increases in excess or co-payment > 50%
- At least 50 days notice to affected contributors

- Notice to outline "upgrade" options in and outside the insurer
- Pre- booked admissions (prior to notification) unaffected
- Patients currently in a "course of treatment" to be unaffected (for up to 6 months).

2. Other detrimental changes to hospital benefits

- At least 30 days notice to affected contributors
- Notice to outline "upgrade" options in and outside the insurer
- Pre- booked admissions (prior to notification) unaffected
- Patients in a "course of treatment" (at time of notification) to be unaffected (for up to 3 months).

3. Changes to ancillary benefits (detrimental)

- At least 30 days notice to affected contributors
- Changes to annual limits and withdrawal of benefits subject to annual limits to take effect from beginning of next annual period
- "Rollover"/ bonuses accumulated within the previous year to be honoured.

+ For all detrimental changes

- Flexibility to deal with special or unusual circumstances on a case by case basis.

It is timely to remind insurers that product closures and forced migrations to new products can involve detrimental changes to cover. A recent example is where an insurer forcibly migrated a sizeable group of members from a product with full hospital cover (but for a limited number of days per year) and no excess or co-payment, to a level of cover with an excess and restrictions on a number of important services, including obstetrics, major eye surgery and joint replacement surgery. The insurer's letter to members did not alert them to any of these detrimental changes to their cover, but only highlighted the addition of a number of new ancillary services.

PHIO's view is that where members are moved to a cover with restrictions, or restrictions are added to an existing cover; they should be specifically alerted to the restriction in an individual letter and advised of appropriate levels of cover if they do not want a cover with restrictions. PHIO's view is also that with forced migrations, it is best practice for all waiting periods to be waived.

Complaints by Health Fund Market Share

01 October - 31 December 2007

Name of Fund	Complaints[1]	Percentage of Complaints	Level-3 Complaints[2]	Percentage of Level-3 Complaints	Market Share[3]
ACA Health Benefits	0	0	0	0	<0.1
AHM	18	4.2	5	3.5	2.7
Australian Unity	30	7.1	12	8.3	3.4
BUPA (HBA)	43	10.1	16	11.1	9.8
CBHS	3	0.7	1	0.7	1.2
CDH (Cessnock District Health)	0	0	0	0	<0.1
Credicare	1	0.2	0	0	0.4
Defence Health	5	1.2	2	1.4	1.4
Doctors' Health Fund	1	0.2	0	0	0.1
Druids Victoria	1	0.2	1	0.7	0.1
GMHBA	4	0.9	2	1.4	1.5
Grand United Corporate Health	1	0.2	0	0	0.3
HBF Health	12	2.8	3	2.1	7.6
HCF (Hospitals Cont. Fund)	21	4.9	6	4.2	8.8
Health Care Insurance	0	0	0	0	0.1
Health Insurance Fund of W.A.	4	0.9	2	1.4	0.4
Healthguard	0	0	0	0	0.5
Health-Partners	2	0.5	1	0.7	1.1
Latrobe Health	1	0.2	0	0	0.6
Manchester Unity	9	2.1	6	4.2	1.6
MBF Alliances	11	2.6	4	2.8	2.1
MBF Australia Limited	107	25.2	31	21.5	15.9
Medibank Private	103	24.2	34	23.6	28.6
Mildura District Hospital Fund	0	0	0	0	0.3
National Health Benefits Aust.	1	0.2	1	0.7	<0.1
N.I.B. Health	31	7.3	12	8.3	6.6
Navy Health	0	0	0	0	0.3
Peoplecare	0	0	0	0	0.3
Phoenix Health Fund	0	0	0	0	0.1
Police Health	0	0	0	0	0.2
Queensland Country Health	1	0.2	0	0	0.2
Railway & Transport Health	5	1.2	2	1.4	0.3
Reserve Bank Health	0	0	0	0	<0.1
St Lukes Health	2	0.5	0	0	0.4
Teacher Federation Health	6	1.4	2	1.4	1.7
Teachers Union Health	2	0.5	1	0.7	0.4
Transport Health	0	0	0	0	0.1
Westfund	0	0	0	0	0.7
Total for Registered Funds	425	100	144	100	100

1. Number of Complaints (Levels 1, 2 & 3) from those holding registered health fund policies.
2. Level 3 Complaints required the intervention of the Ombudsman and the health fund.
3. Source: PHIAC, Market Share, All Policies, 30 June 2007