

# **Bupa Health Insurance Hospital Policy Changes**

June 2018

Report by the Commonwealth Ombudsman,  
Michael Manthorpe, under the *Ombudsman Act 1976*

REPORT NO. **05 | 2018**

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## EXECUTIVE SUMMARY

The Commonwealth Ombudsman in its role of investigating complaints has insight into many of the consumer issues raised by Bupa's recently announced detrimental changes to hospital insurance policies. Typically with other insurers in the past, the Office of the Commonwealth Ombudsman (the Office) receives complaints about policy exclusions and restrictions, and the communication of policy changes by health insurers. Less frequently, the Office receives complaints about problems experienced by consumers in electing to be private patients in public hospitals.

This report discusses two changes that are being made by Bupa which will have a detrimental impact on consumers. The first is policy restrictions becoming exclusions on Bupa's basic and mid-level hospital policies. The second is alterations that Bupa has made to its medical gap scheme affecting non-contracted hospital and public hospital admissions.

The impact of the change to exclude rather than pay partial benefits towards a list of services on its basic and mid-level hospital policies is outlined in this report. In summary, the change removes an entire benefit from payment, including the hospital accommodation, prosthesis, medical gaps and other benefits previously eligible for benefit.

The impact of Bupa's change to its medical gap schemes and to reduce benefits particularly in public hospitals is less clear. The financial impact of the change on a single episode of hospital admission for an individual may be small, as the reduction in benefits only applies to the medical gap benefit that Bupa pays above the Medicare Schedule Fee. We also note that some consumers may opt to use the public system instead which makes the impact of the change more complex to approximate, because although there may be no cost to a consumer by electing to be a public patient, the less tangible benefit of being able to choose your own doctor is difficult to measure.

The Office acknowledges that it is a commercial decision for private health insurers to determine the extent of cover it provides over and above its statutory requirements as it seeks to balance increasing health costs against the goal of minimising premium increases and, in the case of for-profit funds, achieving a reasonable return on investment for shareholders or owners.

We also acknowledge that certain other providers have taken decisions to reduce or remove minimum or restricted benefits. Australia's systems of health funding and health insurance are complex. However, it is imperative that if a fund is to make significant changes to its policies which may have a detrimental impact on consumers that the changes are explained in plain English and in a way that prominently communicates their potential impact.

The Office will continue to monitor this issue and if there is a significant increase in complaints from Bupa policyholders about any of the changes it has made, this will be raised with Bupa and if appropriate, reported in the PHIO quarterly bulletins<sup>1</sup> or a special report on the subject.

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<sup>1</sup> PHIO Quarterly Bulletins <http://www.ombudsman.gov.au/about/private-health-insurance/private-health-insurance-publications/private-health-insurance-quarterly-bulletin/archived-private-health-bulletins>

## Role of the Private Health Insurance Ombudsman

The Commonwealth Ombudsman's role as the Private Health Insurance Ombudsman (PHIO) is to protect the interests of private health insurance consumers, including:

- assisting health fund members to resolve disputes through our independent complaint-handling service
- identifying underlying problems in the practices of private health funds or health care providers in relation to the administration of private health insurance
- providing advice to government and industry about issues affecting consumers in relation to private health insurance
- providing advice and recommendations to government and industry about private health insurance, specifically the performance of the sector and the nature of complaints.

## Background

In late February 2018, Bupa Health Insurance (Bupa) announced significant changes to policies affecting consumers with basic and mid-level hospital policies and to its medical gap scheme on all hospital policies, in conjunction with its 3.99 per cent average premium increase announcement.

The Office has been approached by the Minister for Health, the Hon. Greg Hunt MP as well as members of the public with respect to the two most significant policy changes, which have the potential to affect a large number of consumers detrimentally. For this reason, the focus of this report is on the following policy changes and the potential effect on consumers.

### ***Policy restrictions becoming exclusions***

On basic and mid-level hospital policies, Bupa is removing restricted benefits for:

- hip and knee replacements
- cataract and eye lens procedures
- renal dialysis for chronic renal failure
- pregnancy and birth related services
- IVF and assisted reproductive services
- obesity related procedures and surgeries
- abdominoplasty and lipectomy procedures.

Bupa has advised that these changes will affect 720,285 policyholders.

Until 1 July 2018, policyholders are eligible to receive a "restricted" benefit – this is a partial benefit for these services and for the hospital accommodation charges and a standard benefit for the prosthesis and medical gap charges in all hospitals in Australia. From 1 July 2018, these benefits will be removed and no benefits will be paid to policyholders.

### ***New conditions on medical gap benefits***

From 1 July 2018, Bupa has announced it would no longer pay the above Medicare Benefit Schedule referred to as the "medical gap" benefit for all Bupa policyholders electing to be private patients in public hospitals or attending non-contracted facilities.

Following the initial announcement of this change, Bupa advised it would allow benefits to continue for those patients in public hospitals who are pre-booked admissions. The Office requested further information from Bupa on what was considered to be included in this category of patients. Bupa has indicated that it includes patients who have “pre-booked” their admission, defined as at least 48 hours in advance.

The effect of Bupa’s change to the payment of medical gap benefits in public hospitals on the remaining emergency and unbooked admissions and whether these patients will continue to elect to be private patients in public hospitals is uncertain.

It should be noted that Bupa also announced a number of other smaller policy changes to policies which are not the subject of this report.

## **Issues**

### ***Policy restrictions becoming exclusions***

Currently 720,285 policyholders have chosen Bupa policies that pay restricted benefits for a range of services. These consumers have elected to forgo being fully covered for all services in exchange for a lower premium. Considering the number of policyholders holding Bupa’s basic and mid-level hospital policies, this represents a large group of consumers whose decision about their health insurance coverage is affected by Bupa’s policy changes. This report provides some case examples to illustrate the potential effect of this change on consumers.

After this policy change comes into effect these consumers need to consider whether to accept the lower level of health coverage, or whether to upgrade to a more expensive level of cover.

#### ***Case example***

##### ***Hip replacement surgery in private hospitals***

A consumer holding Bupa basic or mid-level hospital cover is currently partially covered for treatment in a private hospital for a hip replacement.

Up until 1 July 2018 they are covered for the surgeon’s fee, anaesthetic, prosthesis, pathology and other medical services to the same level as a top level hospital cover. For hospital accommodation and theatre charges, they receive a restricted or “minimum default” benefit of between \$277 and \$394 per day. The consumer is required to pay the balance of the daily hospital accommodation charges and the theatre fee, which varies depending on the treatment and facility.

Under the current policy, a consumer would expect to receive approximately half the cost back on a \$25,000 hip replacement surgery, because a standard hip prosthesis costs approximately \$10,000 and Bupa also contributes a significant amount of the costs of accommodation and doctor charges.

From 1 July 2018 this consumer will receive no benefits from Bupa for hip replacement surgery. If the consumer proceeds with treatment in a private facility they will pay the entire costs of approximately \$25,000.

***Case example (continued)***

If the consumer opts to use the public system they will face a waiting list of up to three years for hip replacement surgery depending on where they reside and their medical status. If they upgrade to a higher health insurance policy after 1 July 2018 to avoid the wait time in the public system, a 12 month waiting period will apply as it would be considered a pre-existing condition.

***Case example***

***Childbirth in public hospitals***

A consumer who holds basic or mid-level cover is currently fully covered for hospital charges in a public hospital if they elect to be a private patient. They are also covered for their obstetrician charges up to the Medicare Schedule Fee and possibly more if they participate in Bupa's gap cover arrangements.

From 1 July 2018, a benefit is no longer payable for obstetrics. If the consumer proceeds with treatment as a private patient in the public hospital they will pay approximately \$300–\$400 a day in hospital charges and the entire gap on their medical specialist fees charged over the amount Medicare contributes.

The consumer may choose not to be a private patient in the public facility in which case they will pay nothing, but they will no longer be able to choose their own obstetrician.

***Cost of upgrading to nearest equivalent hospital insurance policies***

The Office sought information from Bupa about the likely additional cost for a consumer seeking to maintain coverage for the list of restricted services by upgrading to the next highest cover.

Bupa provided information on the anticipated additional cost to consumers seeking to upgrade their policy in response to the changes. It should be noted that these should be considered estimates because there are many variables involved in calculating a health insurance premium, such as level of cover, excess or co-payment chosen, state/territory of residence, government rebate tier, lifetime health cover loading and whether the policy is single, couple, family or other. Details of the anticipated additional costs are provided in **Attachment A**.

***Effect of changes to basic and mid-level hospital policies on consumers in regional Australia***

A number of consumers in regional Australia choose basic health insurance policies that are only sufficient to cover the cost of treatment in a public hospital. Some consumers do so simply as a result of not needing more expensive insurance to provide benefits for private hospitals which are too far away to use.

The change that Bupa will be making to its basic and mid-level hospital insurance policies will affect some consumers in regional Australia more than their metropolitan counterparts who elect to pay for higher levels of health insurance to access private hospital services. However, the number of consumers involved is unknown, given the limited data available.

These consumers in regional Australia are faced with either accepting the lower level of cover that comes into effect after 1 July 2018 or upgrading their insurance, either with Bupa or another insurer. The additional premium costs are discussed earlier in this report.

Although consumers in regional Australia have the option to upgrade their policy to maintain cover, it seems an undesirable option for them to pay for a more expensive policy that will cover them for private hospitals which they cannot access due to their geographic location.

For this reason they may experience higher levels of dissatisfaction with Bupa's policy changes and seek alternative cover with other insurers. If these consumers do choose to upgrade their cover or transfer to another insurance company before 1 July 2018, they will not be required to re-serve waiting periods on their new policies. However, it is important that they understand the change being made by Bupa and act before 1 July 2018, in order to avoid waiting periods being applied.

**Case example**

***Consumer in regional Australia, with restricted benefits in public hospitals***

Some consumers choose basic levels of private health insurance because they are unlikely to require treatment in a private hospital due to their location. For customers living in regional Australia, their local medical practitioners are more likely to treat them in nearby public hospital facilities.

Restricted benefits are sufficient to cover consumers with access to only public hospitals as private patients, for all services able to be performed in the facility and a gap benefit for fees charged by their doctors. They may still be required to pay for a portion of the doctor fees if the provider's charges are higher than the Medicare and Bupa benefit.

From 1 July 2018, a consumer holding a Bupa policy with restricted benefits is no longer covered as a private patient in a public hospital for hip and knee replacements, cataract and eye lens procedures, renal dialysis for chronic renal failure, pregnancy and birth related services, IVF and assisted reproductive services, obesity related procedures and surgeries and abdominoplasty and lipectomy procedures.

The consumer may choose not to be a private patient in the public facility in which case they will pay nothing, but they will no longer be able to choose their own doctor.

***New conditions on medical gap benefits***

Bupa is reducing the level of cover it provides for medical gap scheme benefits on all of its hospital insurance policies effective 1 August 2018. Bupa has advised that this change will affect 1,474,427 policies.

The Bupa medical gap scheme provides top-up benefits for medical services. Bupa pays over and above the Medicare Schedule Fee<sup>2</sup> under certain conditions. A doctor who chooses to charge within the conditions of the scheme is considered to be participating.

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<sup>2</sup> For services in hospital that are eligible for health insurance benefits there is a Medicare Schedule Fee. For in hospital treatment, Medicare contributes 75% of the schedule fee and a health insurer pays at least 25% of the schedule fee. Medical Gap Schemes such as Bupa's provide benefits above the Medicare Schedule Fee.

The main conditions<sup>3</sup> that apply to such schemes is that the doctor's fees are within a certain range allowed above the Medicare Schedule Fee and that informed financial consent is obtained from the patient for their contribution.

Under the current policy, the hospital a patient attends is not relevant to whether benefits are paid under Bupa's medical gap scheme.

From 1 August 2018, Bupa will no longer pay gap scheme benefits for admissions to hospitals which are not in their network of contracted hospitals.

As Bupa has not<sup>4</sup> entered into contracts with public hospitals but does enter into contracts with private hospitals, this change will predominantly effect consumers seeking to be private patients in public hospitals. It will also effect consumers seeking to be private patients in private hospitals that are not within Bupa's networks of contracted hospitals.

Since announcing the change, Bupa has advised it will continue to pay the medical gap scheme benefits in public hospitals, if the admission is considered to be pre-booked. The Office has been advised that for Bupa to consider an admission to be non-emergency, the patient needs to have been booked into the public hospital at least 48 hours before admission and for an "eligibility check" to have been performed by the hospital (i.e. the hospital contacts Bupa to confirm the details of a patient's health insurance). It is unclear to the Office how Bupa will inform policyholders of this change before the gap scheme change takes effect on 1 August 2018.

The Office considers a significant number of policyholders may be affected by the change because many patients are admitted to public hospitals via the emergency department and others are admitted urgently after receiving advice from their doctor to seek medical treatment.

As at the time of writing this report (June 2018) the Office had received a small number of complaints from consumers and one from a private hospital<sup>5</sup> about this change. A number of stakeholders within the industry such as medical providers, health insurers and the media have commented on the potential impact of the changes, but how consumers will react to the changes and whether they will simply elect to be public patients as a result of Bupa's actions is unknown.

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<sup>3</sup> BUPA describes the Medical Gap Scheme more fully at <https://www.bupa.com.au/medicalgapscheme>

<sup>4</sup> Bupa has advised the Office that it has attempted to form contracts with public hospitals for about 10 years but they have unable to get a contract in place as yet.

<sup>5</sup> The Office received correspondence from one private hospital who is not within Bupa's network of contracted hospitals concerning these changes.



**Case example**

**Consumer in regional Australia, medical gap benefits**

In regional Australia, some consumers elect to be private patients in public hospitals in order to choose their own doctor. For consumers that hold basic and mid-level hospital cover with Bupa they are currently covered for a significant portion of medical gap fees charged by the doctors, though they can still be required to pay an amount if their doctor charges more than the amount Medicare and Bupa will contribute.

From 1 August 2018, a consumer is no longer covered for gap benefits for any service in a public hospital, unless it is booked with the hospital at least 48 hours in advance (and therefore not considered pre-booked admission).

The consumer may choose not to be a private patient in the public facility, in which case as a public patient they will pay nothing, but they will no longer be able to choose their own doctor.

**Communication of policy changes**

The Office has reviewed the communications sent by Bupa in late February and early March 2018 to policyholders advising of the policy changes effective on 1 July 2018. It is important that health insurers advise policyholders that their policy is being reduced as it provides consumers with the opportunity to upgrade their health insurance policy, either with Bupa or another insurer, to ensure they maintain their level of cover for the services affected.

There are also time limits in which consumers need to elect to make changes to their policies without delay or they will be required to serve a 12 month waiting period on conditions deemed to be pre-existing by their insurer for any new or higher benefits on their new policy.<sup>6</sup>

The Australian Competition and Consumer Commission (ACCC) has provided guidance to health insurers about the need to provide clear and unambiguous notifications of detrimental rule changes.

In its 2014–15 report to the Australian Senate entitled “Communicating changes to private health insurance benefits” the ACCC discussed the need for insurers to clearly and unambiguously notify changes to policy holders.<sup>7</sup> The ACCC also indicated a willingness to take action where it considers intervention is warranted.

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<sup>6</sup> For a more details on transferring health insurance policies refer to guidance provided by the Commonwealth Ombudsman in the brochure “The Right to Change”  
[http://www.ombudsman.gov.au/data/assets/pdf\\_file/0020/29423/Right-to-Change-DL-Fyler-Web.pdf](http://www.ombudsman.gov.au/data/assets/pdf_file/0020/29423/Right-to-Change-DL-Fyler-Web.pdf)

<sup>7</sup> The ACCC 2014-15 report to the Australian Senate “Communicating changes to private health insurance benefits”  
[https://www.accc.gov.au/system/files/1109\\_Private%20Health%20Report%202014-15\\_FA1\\_web.pdf](https://www.accc.gov.au/system/files/1109_Private%20Health%20Report%202014-15_FA1_web.pdf)

The Office recognises the different roles of the ACCC and the Commonwealth Ombudsman and that our focus is on complaint-handling and the practices of health insurers, rather than definitive decisions about whether a particular notification was adequate or not.

An example of Bupa’s notification is provided at **Attachment B**. The information confirming the removal of benefits for certain services is included under the heading “Maintaining the affordability of your cover”.

However, this important information is included after a section on “Improving the value of your cover”. The “improvements” section itself is a mix of improvements and a significant reduction in Bupa’s medical gap scheme coverage. It is difficult to say whether some consumers will overlook or misunderstand the fact that their policy has been downgraded because of the design of this communication.

The Office considers that the ordering of this communication would more efficiently convey information to consumers if it included the premium increase first as the most important change. Detrimental changes to the policy are the second most important change and should be included at the top of the communication under a heading that correctly identifies it as a reduction in benefits rather than an “improvement”. Any additional information and promotional material should then be included below these important messages.

## Conclusions

The findings of the Office’s examination of Bupa’s changes to basic and mid-level hospital policies is that this change will affect some consumers to a greater extent in regional areas. For all consumers affected by the change, both in regional and metropolitan areas, the change to these covers means they will need to decide by 1 July 2018 whether to accept a lower level of cover or to upgrade to a more expensive policy with Bupa or another insurer. Recognising the need to adequately communicate the urgency for consumers to act, the Office makes two recommendations to Bupa below.

After considering Bupa’s changes to its medical gap scheme the Office similarly concludes that the change will affect some consumers in regional areas to a greater extent. Similar to the hospital policy changes regional consumers are affected more due to them being more likely to attend a public rather than a private hospital.

The eventual effect of the change is uncertain because consumers may choose to switch to being public patients in hospitals when they are asked to provide informed financial consent to costs. The Office will monitor complaints about this issue and report further if this change proves to be a problem for consumers.

## Recommendations

Arising from this investigation, the Office makes the following recommendations for action by Bupa:

### Recommendation 1

That Bupa carefully review the appropriateness and effectiveness of its first communication of February 2018 to policyholders. The Office has previously provided advice to insurers about making policy changes in its PHIO Quarterly Bulletin 69<sup>8</sup> and the ACCC has provided guidance in its 2014–15 report<sup>9</sup> on the subject of notifying policy changes.

### Recommendation 2

The next communication to policyholders should give increased prominence to the detrimental changes and provide consumers with clear information that they need to take action before 1 July 2018 if they wish to maintain their current level of health insurance benefits.

The Office is able to provide comments and suggestions on proposed policy change communications. The Commonwealth Ombudsman also investigates and reports on complaints about health insurance communication as part of its complaint investigation function.

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<sup>8</sup> [http://www.ombudsman.gov.au/\\_data/assets/pdf\\_file/0015/27510/qb69.pdf](http://www.ombudsman.gov.au/_data/assets/pdf_file/0015/27510/qb69.pdf)

<sup>9</sup> The ACCC 2014-15 report to the Australian Senate “Communicating changes to private health insurance benefits”  
[https://www.accc.gov.au/system/files/1109\\_Private%20Health%20Report%202014-15\\_FA1\\_web.pdf](https://www.accc.gov.au/system/files/1109_Private%20Health%20Report%202014-15_FA1_web.pdf)

## ATTACHMENT A: ADDITIONAL AVERAGE YEARLY COST OF UPGRADING HOSPITAL POLICIES

Standard \$500 Excess to Top \$500 Excess (excluding rebate)

	Single	Couple	Family	Single parent family
NSW/ACT	\$144	\$288	\$288	\$332
VIC	\$152	\$305	\$305	\$317
QLD	\$151	\$302	\$302	\$316
WA	\$153	\$306	\$306	\$256
SA	\$157	\$314	\$314	\$345
TAS	\$133	\$265	\$265	\$392
NT	\$124	\$247	\$247	\$203

Budget \$500 Excess to Top \$500 Excess (excluding rebate)

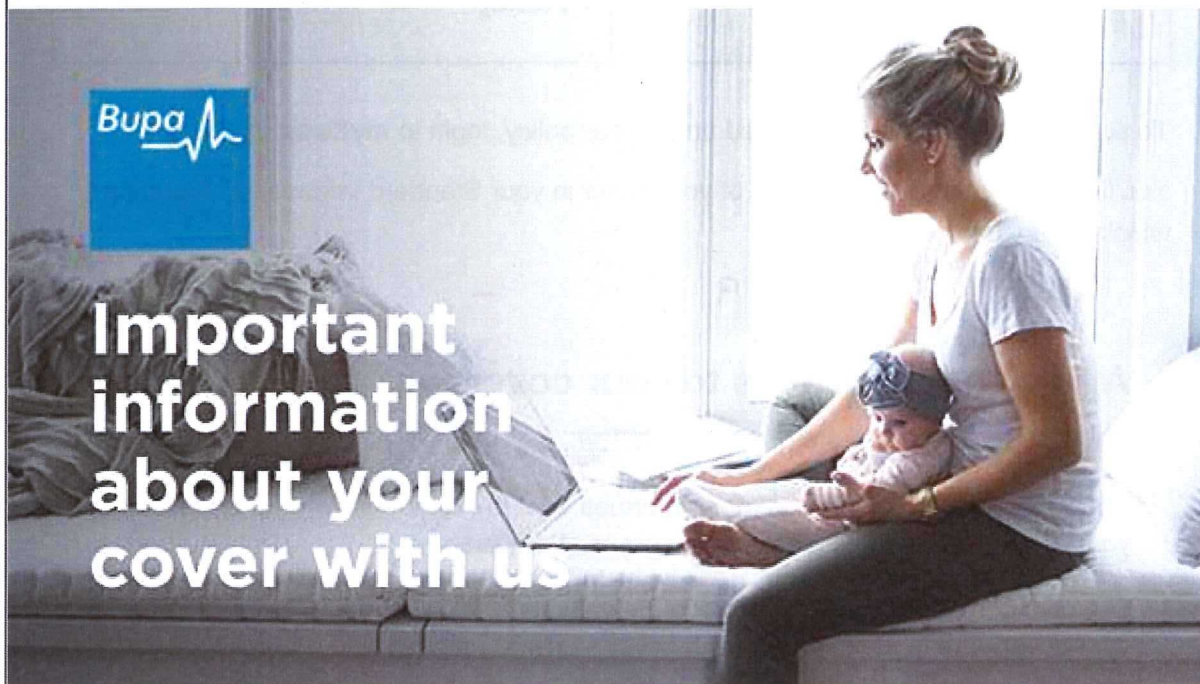
	Single	Couple	Family	Single parent family
NSW/ACT	\$865	\$1,729	\$1,729	\$1,567
VIC	\$905	\$1,810	\$1,810	\$1,736
QLD	\$898	\$1,796	\$1,796	\$1,684
WA	\$716	\$1,433	\$1,433	\$1,335
SA	\$598	\$1,196	\$1,196	\$1,195
TAS	\$766	\$1,531	\$1,531	\$1,281
NT	\$348	\$696	\$696	\$580

**Basic \$500 Excess to Top \$500 Excess (excluding rebate)**

	<b>Single</b>	<b>Couple</b>	<b>Family</b>	<b>Single parent family</b>
<b>NSW/ACT</b>	\$1,041	\$2,082	\$2,082	\$1,847
<b>VIC</b>	\$1,133	\$2,266	\$2,266	\$2,087
<b>QLD</b>	\$1,069	\$2,137	\$2,137	\$1,949
<b>WA</b>	\$898	\$1,795	\$1,795	\$1,616
<b>SA</b>	\$791	\$1,583	\$1,583	\$1,494
<b>TAS</b>	\$1,017	\$2,034	\$2,034	\$1,700
<b>NT</b>	\$429	\$858	\$858	\$716

## **ATTACHMENT B: AN EXAMPLE OF BUPA'S NOTIFICATION FEBRUARY 2018**

See what's changed and how to get more value in 2018  
 Can't read this email? [Click here](#) to view in your browser.



# Important information about your cover with us

Membership number:

## Hi to the

We recently completed our annual review of premiums and the benefits covered on your Bupa health cover. This email will explain any updates to your policy, so be sure to read it thoroughly.

## Your new premium

From 1 April 2018, your premium will change as part of an annual industry-wide, Government regulated review.

Bupa is working hard to keep your premium increase as low as possible. Find out why premiums increase, plus how the reduced Government Rebate impacts your premium, [here](#).

Your current premium	Your new premium
<p><b>\$377.00</b> per month                      INCLUDING your current rebate of <b>\$98.60</b>                      per month</p>	<p><b>\$393.61</b> per month                      INCLUDING your new rebate of <b>\$100.25</b> per                      month</p>

Rebate percentages are indexed annually. Your Australian Government Rebate changes from 25.934% to 25.415% as at 1 April 2018.

## Your cover details

Level of cover:	Membership type:
Budget Hospital with \$500 Excess and Silver Extras	Family

To see the details of what's covered under your policy, login to [myBupa](#).

You'll find the most current details of your cover in your Standard Information Statement, which is attached.

## At a glance: changes to your cover

Changes to your cover are highlighted below.

You'll find a full summary and more information of the **changes to your cover** in your [myBupa inbox](#), which you can access at any time.

Our changes are intended to improve the value and maintain the affordability of your cover, and to make your health cover easier to understand.

### Improving the value of your cover:

- The Bupa Medical Gap Scheme is designed to eliminate or minimise specialist/medical costs you will have to pay when admitted to hospital as an 'inpatient'. From 1 August 2018, we're changing the way the **Bupa Medical Gap Scheme** works:
  - If your specialist chooses to use The Bupa Medical Gap Scheme, it will only apply when you are admitted to a hospital with which Bupa has a Members First, Network or Fixed Fee agreement. These facilities have arrangements with Bupa which will provide you with certainty on hospital accommodation costs and theatre fees associated with your treatment.

Find a participating hospital or Medical Gap Scheme provider [here](#).

- From 1 April 2018, we're adding more value to your family's hospital cover by including **No Excess for kids** (up to the age of 25).
- We know that mental health is a significant issue for Australians and so we want to make the path to getting help clearer for those who need it. That's why from 1 July 2018, your Psychology cover will now move to a **new 'Mental Health'** service category on your extras cover, which will allow us to pay benefits towards Bupa recognised Psychologists and Counsellors.

### Maintaining the affordability of your cover:

- Feedback from customers has shown the value of 'minimum benefits' (restricted cover) included in their health cover were not clear. To help keep premiums as low as possible, we're no longer paying benefits on the following services from 1 July 2018:
  - hip and knee replacement
  - cataract and eye lens procedures



- renal dialysis for chronic renal failure
- pregnancy and birth related services
- IVF and assisted reproductive services
- obesity related procedures and surgeries
- abdominoplasty and lipectomy

Here's a **comparison summary** to help you understand what benefits you'll be covered for as of 1 July 2018. **Learn more** about what minimum benefits are and why we are making this change. If you have been on this level of cover since before 1 March 2018, and would like to continue to be covered for any of these services, upgrade your cover by 1 July 2018 and we'll waive your hospital waiting periods, **find out more**.

- From 1 July 2018, we'll no longer cover **spinal fusion** on your health cover.

#### **Making your cover easier to understand:**

- From 1 April 2018, instead of 'Gastric banding and Obesity', we will be calling these treatments '**Obesity related procedures and surgeries**'.
- On your cover we pay benefits towards breast augmentation (when clinically necessary). From 1 July 2018, we will continue to cover you for **reconstructive surgery**. We will not cover you for any breast procedures except when they are post breast cancer. We are also updating our Fund Rules to clarify the definition of **Cosmetic Surgery** so you have a better idea of what is excluded and deemed as Cosmetic Surgery.

#### **Updates to our Fund Rules:**

- We're making changes to our Fund Rules from 1 July 2018, which you will find outlined in the changes to your cover summary. You can access a summary of the changes **here**.



#### **Coming soon: Gap-Free Dental check ups**

We're always looking for ways to deliver better value health cover for our members. That's why, from 1 September 2018, we're introducing 'gap free' dental care on a number of common preventative dental services, at selected Members First dentists. Keep an eye out for more information whilst we are expanding this offer at selected Members First dentists.

### **Discover the plusses of being with Bupa**





### Tips to get more value from your cover

Understanding what you're covered for can be confusing. These tips will help you better understand your benefits, and how you can make the most of your cover in 2018.

[Read tips >](#)



### Why do I need health insurance?

Bupa Health Insurance gives you the flexibility and control you deserve - with choice around treatment, the option to claim costs that may not be covered by Medicare, and potential tax savings.

[Read more >](#)



### Bupa Plus

Your family has access to a world of discounts, offers and helpful information - from discounted movie vouchers to theme park visits.

[Go now >](#)



Call 134 135



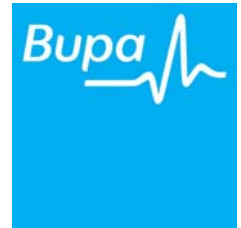
Visit your local Bupa store



Visit [bupa.com.au](http://bupa.com.au)

This email was sent by Bupa HI Pty Ltd ABN 81 000 057 590 - 33 Exhibition Street, Melbourne, VIC 3000, Australia (Bupa). Bupa values your privacy. You can change how we send you membership communications by logging in to **myBupa**. Please do not reply to this email. Replies go to an unmonitored mailbox. If you have any questions or feedback go to [bupa.com.au](http://bupa.com.au) or call 134 135.

## **ATTACHMENT C: BUPA'S RESPONSE TO THE RECOMMENDATIONS**



25 May 2018

Mr Michael Manthorpe PSM  
Commonwealth Ombudsman  
Level 5, 14 Childers Street  
Canberra ACT 2601

**Bupa Health Insurance**  
33 Exhibition Street  
Melbourne Victoria 3000

GPRA@bupa.com.au  
bupa.com.au

**Via email: [Michael.Manthorpe@ombudsman.gov.au](mailto:Michael.Manthorpe@ombudsman.gov.au)**

Dear Mr Manthorpe,

## **Re: Issues Paper – Bupa Hospital Policies Change**

Thank you for the opportunity to respond to the draft issues paper attached to your letter dated 14 May 2018, regarding Bupa HI Pty Ltd's (**Bupa's**) impending hospital policy changes.

We are committed to communicating to our customers clearly and have carefully considered the recommendations made in the Issues Paper and set out our responses below.

### **1. Recommendation 1**

*Bupa carefully review the appropriateness and effectiveness of its first communication of February 2018 to policyholders. The Office has previously provided advice to insurers about making policy changes in its PHIO Quarterly Bulletin 69<sup>1</sup> and the ACCC has provided guidance in its 2014-15 report<sup>2</sup> on the subject of notifying policy changes.*

We acknowledge that, despite our efforts to communicate to our customers in clear and transparent language, there is scope for improvement.

We have reviewed our February/March communication to our customers. While the communication aimed to be clear and transparent regarding the relevant detrimental changes to our customers' policies, we now recognise that the communication was not as effective as it could have been, had we taken the approach indicated by the Commonwealth Ombudsman and the ACCC respectively, in the above-mentioned publications.

We will use the model recommended by the Commonwealth Ombudsman in its *PHIO Quarterly Bulletin 69* in all future notifications to our customers about detrimental changes to their policies. In particular, we will ensure that headings signal the nature of any change and detrimental changes are displayed in a prominent position towards the top of the first page of any letter or email.

### **2. Recommendation 2**

*The next communication to policyholders should give increased prominence to the detrimental changes and provide consumers with clear information that they need to take action before 1 July 2018 if they wish to maintain their current level of health insurance benefits.*

We welcome the opportunity to work with the Commonwealth Ombudsman to ensure that changes are re-communicated in a way that is easier for our customers to understand and decide what they need to do.

A number of affected customers contacted us to take up our offer to upgrade to a policy covering the treatments now excluded, without serving waiting periods. However, we recognise the Ombudsman's concern that some customers who were affected may not have known how that change impacted them or what they needed to do to maintain cover for these services.

<sup>1</sup> [http://www.ombudsman.gov.au/data/assets/pdf\\_file/0015/27510/gb69.pdf](http://www.ombudsman.gov.au/data/assets/pdf_file/0015/27510/gb69.pdf)

<sup>2</sup> The ACCC 2014-15 report to the Australian Senate "Communicating changes to private health insurance benefits" [https://www.accc.gov.au/system/files/1109\\_Private%20Health%20Report%202014-15\\_FA1\\_web.pdf](https://www.accc.gov.au/system/files/1109_Private%20Health%20Report%202014-15_FA1_web.pdf)

As a result, we will extend the period during which those customers who are affected can upgrade their cover without having to re-serve waiting periods. The previous date of 1 July 2018 is extended to a new date of 1 September 2018.

We have listened to our customers and know that the changes announced in relation to the Medical Gap Scheme in public hospitals led to some concern. We also want to see value for money and no surprises over gap charges from doctors for our customers.

We have decided to ensure a medical gap scheme continues to be available for public hospitals. This means that our customers who are treated in a public hospital can have peace of mind around out-of-pocket costs while maintaining choice of doctor. This scheme would see patients face out of pocket medical bills from doctors in public hospitals of no more than \$500 for pre-booked admissions and no gap for all other public hospital admissions if a doctor chooses to use the scheme.

We want to communicate the upgrade extension and the public hospital medical gap scheme to all affected customers as quickly as possible. So we intend to issue a public statement prior to 1 July 2018 communicating the extension of time to take up the upgrade offer linked to minimum benefits as well as Bupa's position on medical gap coverage in public hospitals. This public statement will also reflect the commitment given above in response to Recommendation 1.

We will follow this up with a further direct communication to affected customers about the changes. This communication will be in line with our response to your Recommendation 1, and will be sent in July 2018. We intend to prioritise those customers who live in rural and regional areas in line with the Ombudsman's concerns.

We remain committed to initiatives which help improve certainty and transparency for our customers, in particular reducing the risk of unexpected out-of-pocket costs. This was a key driver behind the changes to minimum benefits and the Medical Gap Scheme changes. We of course welcome all opportunities to work constructively with Government, hospitals and the medical community to achieve outcomes for health consumers on these important issues.

Thank you again for the opportunity to provide our response to the above recommendations. Please do not hesitate to contact me on (03) 03 9937 4335 should you require any further clarification or information.

Yours sincerely,



**Richard Bowden**  
Chief Executive Officer  
Bupa Australia and New Zealand