Australian Government

Private Health Insurance Ombudsman

Agreement Termination – Transition and Communication Protocols

The following protocols are arrangements agreed within the private health industry to ensure adequate consumer protection and minimise undue disruption and risk to the industry when contractual agreements between health funds and hospitals are terminated.

The protocols have been developed by the Private Health Insurance Ombudsman, in consultation with the Australian Health Insurance Association, the Health Insurance Restricted Membership Association of Australia, the Australian Health Services Alliance, the Australian Private Hospitals Association and the Department of Health and Ageing.

December 2009

(Version 1.2)

Introduction

Contract cessation and contractual disputes between insurers and hospitals have the potential to adversely affect consumers' entitlements under their health insurance. The Ombudsman has a role in ensuring the interests of consumers are protected in these circumstances. These Termination and Communication Protocols are intended to provide guidance on appropriate transitional arrangements and communication with members and patients in the event of a contract cessation or dispute. The Ombudsman's expectation is that insurers and hospitals will abide by the Protocols and work in good faith to minimise the impact of these disputes on consumers.

The decision to terminate a contractual agreement is a significant decision for any hospital or health insurer. The financial impact of such a change on the hospital can be considerable, depending on the extent to which those fund members contribute to hospital utilisation and income. Equally, the impact on an insurer can also be significant, depending on the location of and services provided by the hospital, and the potential financial impact of members transferring to other insurers.

Regardless of the financial impact, such changes can be disruptive and confusing to patients, doctors, and the staff of health insurers and hospitals. As with any significant change, disruption and adverse effects can be minimised by effective transition planning and change management.

In addition to considering the financial and management implications for the hospital and health insurer, transition planning and change management should focus on avoiding undue disruption and disadvantage to patients, doctors and staff of health insurers and hospitals. This is important in maintaining a positive, professional working relationship with all healthcare providers and funders and not diminishing the public perception of the value of private health arrangements.

Insurers and hospitals should also ensure that any public statements made by them, or on their behalf, are factual and neutral in tone and not likely to cause confusion and concern to members and patients. Communications that are intended to put the case for one party and denigrate the other can have a negative impact on consumer perceptions of the industry and make it more difficult for the parties to resolve the dispute. Both parties need to bear in mind that in the longer term, they are likely to be in contract again and it is in their interests to take a longer term view of the dispute.

Notice of termination

The terms of the agreement will specify the required minimum notice period for advising of a decision to terminate the agreement. Most agreements will require 30 days as the minimum notice period. The Ombudsman regards this as the absolute minimum period of notice that could be consistent with adequate transition planning and change management. A longer period of notice is preferable in most cases, to ensure that fund members receive adequate notice of the change. A notice period of at least 45 days is likely to be necessary where members of the particular insurer make up a significant proportion of the hospital's admissions or where the hospital provides a significant proportion of services to the insurer's membership. A minimum of 30 days should apply in all other instances.

When a hospital is giving notice of termination, the notice of termination should be in writing to the insurer's provider relations contact (or as specified in the Agreement) and copied to the fund CEO and should clearly indicate the proposed date of cessation of the agreement arrangements.

When an insurer is giving notice of termination, the notice should be in writing to the hospital CEO/and or group CEO (or as specified in the Agreement) and should clearly indicate the proposed date of cessation of the agreement arrangements.

The notice of termination should also include the name and contact details of the staff member responsible for settling and dealing with transition and out-of-contract arrangements, and

request a contact name and details from the other party for these purposes and indicate a willingness to commence discussions on these issues immediately.

Transitional arrangements

On cessation of an agreement, at the end of the period of notice or disengagement, health insurers and hospitals may agree to appropriate transitional arrangements to apply to patients in a range of circumstances. The following transitional arrangements will apply as a minimum:

- Treatment commenced: For patients admitted prior to the effective date of the agreement termination but discharged on or after termination, the terms and conditions of the terminated agreement must apply. The hospital will accept these rates as payment in full (subject to any applicable excess/deductibles).

- Pre-bookings (non maternity): For patients with a booking received by the hospital prior to the date of agreement termination, including bookings notified by the doctor or where the patient has completed the necessary forms, but where admission occurs within six months (or any longer period agreed between the insurer and the hospital) of the date of termination of the agreement, the terms and conditions of the terminated agreement must apply. The hospital will accept these rates as payment in full (subject to any applicable excess/deductibles).

- Maternity pre-bookings: For pre-booked maternity patients with a booking received by the hospital prior to the date of agreement termination, including bookings notified by the doctor, the terms and conditions of the terminated contract must apply. The hospital will accept these rates as payment in full (subject to any applicable excess/deductibles).

- Course of treatment: For all patients undertaking a course of treatment (e.g. chemotherapy, dialysis, psychiatric, rehabilitation*), the terms and conditions of the terminated agreement must apply. The hospital will accept these rates as payment in full (subject to any applicable excess/deductibles). The terms and conditions of the terminated agreement must continue for the duration of the course of treatment or a continuous period of up to 6 months (or any longer period agreed between the insurer and hospital) from the termination of the agreement, whichever occurs first. Insurers and hospitals will be flexible with this timeframe if the patient's particular circumstances make it difficult for them to access alternative services within this timeframe.
  ***NB: Course of treatment is not limited to the examples listed above.**

- Emergency admissions: For emergency admissions, the terms and conditions of the terminated agreement must apply for a continuous period of at least 3 months, or any longer period agreed between the insurer and the hospital, (subject to any applicable excess/deductibles).

The definition of emergency admission will be agreed between the fund and the hospital and such agreement or, in the absence of agreement, will include any of the following:

- At risk of serious morbidity or mortality and requiring urgent assessment and resuscitation; or
- Suffering from suspected acute organ or system failure; or
- Suffering from an illness or injury where the viability of function of a body part or organ is acutely threatened; or
- Suffering from a drug overdose, toxic substance or toxin effect; or
- Experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- Suffering from severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- Suffering acute significant haemorrhaging and requiring urgent assessment and treatment; or

- Patient requires immediate admission to avoid imminent morbidity or mortality and where a transfer to another facility is impractical.

Communications with members/patients

Where there is dispute over a contractual matter, insurers and hospitals will ensure that any public statements made by them or on their behalf are fair and reasonable and do not include any information or comment that could create adverse publicity or negative perceptions of the other party to the dispute.
Information and comment which should be avoided includes:

- Comparison of benefits or prices offered with those applying under agreements with other parties;
- Imputing motives to the other party;
- Commenting on the financial position or ownership structure of the other party;
- Denigrating the quality of services or facilities provided by the other party; and
- Suggesting that consumers do not use the services of the other party.

The Ombudsman will give an opinion and advice on any proposed wording of letters or public statements, if requested to do so, by either party to an agreement termination.

The timing of letters to members and patients should be a matter for discussion between the parties, to minimise confusion to members and patients and ensure they have full information about the issue.

The primary obligation for communication with members rests with the health insurer. This communication **may** include:

- Advice on which hospitals have agreements with the health insurer.
- Advice on which hospitals will no longer have agreements with the insurer
- Advice on the potential for out of pocket expenses for treatment at a non-contracted hospital
- Advice on how to avoid out-of-pocket expenses

The communication **must** include:

- Advice on transitional arrangements

The communications **must not**:

- **Advocate that the member seek treatment in a particular hospital or class of hospitals (e.g. contracted hospitals only).**

The insurer must provide individual written advice to the following categories of members:

- Where possible to do so, patients currently in-hospital or booked for treatment, including maternity and those with on-going arrangements (e.g. chemotherapy);
- Regular patients of the hospital (those patients whose records show they have used the hospital in the past two years);
- Members whose records show they live in the catchment area for the hospital.

The insurer should also communicate more broadly with members who may be affected by press announcement or regular newsletter. The method and extent of communication will depend on the size and location of the hospital and utilisation patterns.

Insurers may choose to communicate with members who are covered by the transitional arrangements, once they receive this information from the hospital, in order to re-assure them that they will be covered for their admission.

Hospitals may also choose to communicate with current, former or potential patients and referring doctors. These communications **may** include:

- Advice on which funds have agreements with the hospital
- Advice on which funds no longer have agreements with the hospital
- Advice on the potential for out of pocket expenses for treatment of members of a non-contracted fund
- Advice on how to avoid out of pocket expenses

The communications **must** include:

- Advice on transitional arrangements

The communications **must not**:

- **Advocate that the member transfer to a particular health insurer or class of insurers (e.g. those with which the hospital has a current agreement).**

Where possible, hospitals should provide insurers with a list of patients who fall within the scope of the transitional arrangements within fourteen days of the date of termination. The insurer will confirm that the list matches their own records and both parties will address any discrepancies within 10 business days from the receipt of the list by the insurer.

Discussions between insurers and hospitals about out-of-contract arrangements for patients not covered by transitional arrangements

Insurers and hospitals will communicate directly with each other to confirm arrangements to apply from the date the agreement is terminated – as soon as practicable after the notice of termination is provided. The Ombudsman expects these matters to be discussed, to some extent, prior to the notice of termination but also expects there to be additional discussion after the notice of termination in order to finalise and confirm:

- The rates of benefit that will be paid by the fund in the out of contract situation (These will vary depending on the approach of the fund, whether or not the hospital is eligible for second tier benefits etc. In some cases the fund may be prepared to maintain old contract rates or higher for some treatments);
- The prices to be charged by the hospital;
- The billing arrangements to apply – both in respect of patients covered by the transitional arrangements and bookings made post termination;
- Arrangements and contacts for dealing with any cases of special circumstance that may arise but are not covered by the general transition arrangements; and
- Approaches to communicating with patients, members and doctors.

Billing Arrangements

Payment or billing arrangements should not be used as a mechanism for pressuring the insurer or hospital. Arrangements that require full upfront payment, in all cases, should be avoided because they unduly disadvantage or inconvenience many patients. A hospital may, however, choose to request upfront payment for any portion of the hospital's charge that is not covered by health fund benefits, provided that informed financial consent for any out-of-pocket costs is obtained from the patient. Health insurers must pay claims within 60 days.

Regardless of the billing arrangements adopted in the out-of-contract situation, it is the Ombudsman's view that hospitals retain an obligation to provide for patient informed financial consent, prior to admission, wherever possible. At a minimum this should include advice of the likely hospital charges and advice that the (prospective) patient should confirm benefits with their insurer, prior to admission, if possible. The hospital should provide as much assistance as possible to enable members to understand what their out of pocket expenses will be.