COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

Termination and Transition Guidelines for Hospitals and Insurers

Introduction

The Termination and Transition Guidelines for Hospitals and Insurers (the guidelines) have been developed in consultation with the private health industry to support consumer protection and minimise undue disruption and risk to the industry when contractual agreements between health insurers and hospitals are terminated.

The guidelines were developed by the Office of the Commonwealth Ombudsman (the Office), in its capacity as the Private Health Insurance Ombudsman. Public consultation on the guidelines was conducted in December 2019, with submissions provided by a range of parties in the private health insurance industry.

They are intended to support the resolution of disputes. They are not legally enforceable but act as a guide for best practice. They operate externally to any existing agreement or arrangement in place between the parties.

Background

Contract cessation and contractual disputes between insurers and hospitals have the potential to adversely affect consumers' benefits under their health insurance. The Office has a role in ensuring the interests of consumers are protected in these circumstances. The guidelines 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 Office's expectation is that insurers and hospitals will abide by the guidelines and work in good faith to minimise 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 insurer's 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 insurers, 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 should 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.

However, a longer period of notice is preferable in some cases, to ensure that affected members receive adequate notice of the change. A minimum notice period of at least 50 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.

The Ombudsman recommends a 50 day notice period as the minimum period of notice consistent with adequate transition planning and change management.

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 insurer's Chief Executive Officer (CEO). The notice 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 copied to the hospital's payer relations contact 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 should apply as a minimum when there is no existing arrangement in place:

- **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 should apply. The hospital should accept these rates as payment in full (subject to any applicable excess/deductibles).

- **Pre-bookings (non-pregnancy and birth)**: 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 should apply. The hospital should accept these rates as payment in full (subject to any applicable excess/deductibles).

- **Pregnancy and birth pre-bookings**: For pre-booked pregnancy and birth 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 should apply. The hospital should 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[1]), the terms and conditions of the terminated agreement should apply. The hospital should accept these rates as payment in full (subject to any applicable excess/deductibles). The terms and conditions of the terminated agreement should 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 should be flexible with this timeframe if the patient's particular circumstances make it difficult for them to access alternative services within this timeframe.

- **Emergency admissions:** For emergency admissions, the terms and conditions of the terminated agreement should 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 should 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.
  - Suffering from suspected acute organ or system failure.
  - Suffering from an illness or injury where the viability of function of a body part or organ is acutely threatened.
  - Suffering from a drug overdose, toxic substance or toxin effect.
  - Experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk.
  - Suffering from severe pain where the viability or function of a body part or organ is suspected to be acutely threatened.
  - Suffering acute significant haemorrhaging and requiring urgent assessment and treatment.
  - Patient requires immediate admission to avoid imminent morbidity or mortality and where a transfer to another facility is impractical.

[1] 'Course of treatment' is not limited to the examples listed above.

Communications with members/patients

Where there is dispute over a contractual matter, insurers and hospitals should 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
- suggesting that consumers do not use the services of the other party.

It is preferable that both parties use the same wording in their communications to avoid any confusion. The Office can give guidance and advice on any proposed wording of communications to members and patients or public statements, if requested to do so, by either party to an agreement termination.

The timing of communications 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.

Where there is no existing arrangement regarding the timing of communication of termination to members and patients, the Ombudsman recommends 50 days' notice for significant changes to hospital benefits and 30 days' notice for other changes to hospital benefits.

Health insurer communications

The primary obligation for communication with members rests with the health insurer.

The Ombudsman recommends that the communication should include advice on transitional arrangements.

This communication may include advice on:

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

The communications should not advocate that the member seek treatment in a particular hospital or class of hospitals (e.g. contracted hospitals only).

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

- where possible to do so, patients currently in-hospital or booked for treatment, including those booked for pregnancy and birth 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), and
- 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.

Hospital communications

Hospitals may also choose to communicate with current, former or potential patients and referring doctors.

The Ombudsman recommends that the communication should include advice on transitional arrangements.

These communications may include advice on:

- which insurers have agreements with the hospital
- which insurers no longer have agreements with the hospital
- the potential for out-of-pocket expenses for treatment of members of a non-contracted insurer, and
- how to avoid out of pocket expenses.

The communications should 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).

Hospitals should provide insurers with a list of patients that fall within the scope of the transitional arrangements as soon as practicable but no later than 14 days after 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 insurer in the out-of-contract situation[2]
- 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 insurer benefits, provided that informed financial consent for any out-of-pocket costs is obtained from the patient.

Health insurers should pay valid claims paid via ECLIPSE within 60 days or as per the relevant contractual agreement.

Regardless of the billing arrangements adopted in the out-of-contract situation, the Ombudsman's view is hospitals retain an obligation to provide for patient-informed financial consent, prior to admission, where practicable.

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.

[2] These will vary depending on the approach of the insurer and factors such as whether or not the hospital is eligible for second tier benefits. In some cases the insurer may be prepared to maintain old contract rates or higher for some treatments)