Private health insurer gap arrangements – information for doctors

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Private health insurers offer gap cover schemes to provide their members with certainty about out-of-pocket expenses for their privately insured medical care. Medical practitioners electing to participate in these schemes must agree to the terms and conditions that are set by the insurer.

Common terms and conditions include that:

- medical practitioners formally register with the scheme
- medical practitioners agree to indemnify the insurer against any claims or liabilities arising from the services provided to an insurer's member
- claims are lodged directly to the insurer or via ECLIPSE in a single consolidated claim
- specific information is provided with the claim, such as patient membership and Medicare numbers, MBS items and breakdown of fees
- no other direct or indirect fee can be charged to the insurer's member
- records are maintained and made available on request, such as in the context of an audit of a medical practitioner's claim for a benefit
- medical practitioners obtain consent from patients for insurers to access their records
- medical practitioners cannot suggest to a patient that they transfer to another insurer
- medical practitioners agree to information about them being published including their name, practice address, contact details, gap agreement usage and participation rate, and average gap charges
- participating medical practitioners cannot not switch between gap and known gap schemes on a patient by patient basis.

Health insurers' terms and conditions for gap arrangements vary considerably and some include only some of the above conditions.

It is essentially up to an individual medical practitioner whether he/she wishes to participate in a gap arrangement.

Information for patients

Members who do not wish to participate in health insurer gap schemes will need to advise patients when obtaining informed financial consent. There is a variety of reasons why a medical practitioner may not wish to participate in gap schemes, however an example of text that could be included in informed financial consent information, is provided below.

> Dr [*insert doctor's name*] does not participate in [*insert health insurer name and gap scheme name*] because [*insert reason, e.g. the benefit payment offered by this health insurer is too low to cover the costs of providing your procedure / it would require him/her to make available your private clinical records to the health insurer / it would require his/her to allow gap cover participation rates to be published on the health insurer's website / it would require him/her to submit claims through Eclipse which is not compatible with this practice's software*].
>
> As a result, your health insurer will only pay 25% of the Medicare Benefits schedule fee for your procedure. You will therefore have out-of-pocket medical costs of [*insert amount*] after Medicare rebates and your health insurer's contribution are taken into account.

Information on issues to consider when providing informed financial consent is available in the AMA position statement on informed financial consent.

The AMA document Guide for patients on how the health care system funds medical care explains to patients the extent to which Medicare and private health insurance covers part of their doctor's fees. However, summary points to explain to patients are as follows.

- Medical practitioners are able to set their own fees for their services to cover the costs of providing the service.

- Medicare rebates do not, and were never intended to, cover the full cost of medical services. The Government sets the amount of the rebate.

- Government indexation of the Medicare rebate has not kept pace with real increases in practice costs.

- Private health insurers set the amount they will pay for each medical service. Private health insurers are required to pay a benefit of at least 25% of the Medicare Schedule Fee. Most insurers set a higher amount they will pay but only if the medical practitioner agrees to limit their fees to that amount.

- It is up to each medical practitioner whether he/she agrees to charge a fee that is equal to that amount. When medical practitioners do not agree to the insurer's level of medical benefit, the insurer will only pay 25% of the Medicare Schedule Fee resulting in out-of-pocket costs for patients.

Audit requirements and patient consent

Some gap arrangements include conditions that require medical practitioners to allow insurers access to patient records in order to audit a medical practitioner's claims for a benefit.

The *Private Health Insurance Act 2007* requires private health insurers to pay benefits for hospital treatment when a member undergoes a procedure for which a Medicare benefit is payable, and which is covered by their health insurance product (section 71-2(2)). Further, any agreement or arrangement with an insurer must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments (section 172-5(1)).

This means that the determination of a clinical treatment regime and the assigning of the relevant Medicare Benefits Schedule item is the exclusive purview of the treating medical practitioner. Under Commonwealth legislation, a medical practitioner has no obligation to provide any further clinical or other information about a patient's procedure to a health insurer.

However, medical practitioners who elect to enter into gap arrangements with insurers where the terms and conditions include complying with audit requirements are agreeing to those conditions.

Some insurers also include a condition that medical practitioners must obtain patient consent to provide their records in the event of an audit. This condition essentially requires a medical practitioner to obtain the cooperation of a third party (the patient).

Given that a medical practitioner cannot guarantee that a patient will provide consent to their records being provided to an insurer, a medical practitioner should not be in breach of an insurer's terms and conditions if a patient does not consent.

The AMA's view is that:

- medical practitioners should never release patient information to a third party without patient consent or an appropriate court order

- if a patient does not provide consent, it is up to the insurer to pursue the matter either with the patient or by obtaining a court order.