Private Healthcare Australia
Better Cover. Better Access. Better Care.

Private Health Insurance Clinical Categories Review

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have more than 20 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for 14.4 million Australians.

Introduction

Introducing clinical categories and product tiers has had a very significant impact on insurer product design. Product development centred on consumer life stages and value in that stage has been replaced with an approach based on body system and the expense of procedure. For example, Gold products just includes all of the most expensive procedures, regardless of whether or not they are relevant to the customer's life stage. Cataracts and joint replacements sit alongside pregnancy/birth and assisted reproductive services.

We need to aim to keep the positive aspects of the clinical categorisation for consumers, in terms of it being easy to understand and compare, while introducing more flexibility for insurers to tailor or differentiate products and give consumers more choice.

In some cases, there are mixed views or different approaches to implementation. PHA has convened a Medical Advisory Group, which included medical practitioners, nurses and health information managers from a mix of large, medium and smaller funds. PHA recommends the Department meet with this group to discuss some of the issues identified below to help inform the government's position.

Response

1. Health to review the current set of examples of medical conditions and procedures listed in the scope of cover of the categories to ensure they are representative of services covered and familiar to most consumers. The review should include consultations with stakeholders.

   Agreed.

2. Categories should clearly indicate if they cover the surgical removal of a tumour and more clearly direct non-surgical cancer treatments to the *Chemotherapy, radiotherapy and immunotherapy for cancer category*.

   Agreed.

3. The eye category should be renamed 'Eyes (other than cataracts)' to reduce consumer confusion over products that also cover the *Cataracts* category.

   There are mixed views among health funds about whether this is necessary, and some suggest consumer testing is required.

4. Amend the scope of cover of *Ear, nose and throat* and *Tonsils, adenoids and grommets* to note tonsils, adenoids and grommets are included in *Ear, nose and throat* in Gold, Silver and Bronze products. Tonsils, adenoids and grommets are listed as a separate category in Basic Plus products.

   Disagree. This will make it harder for consumers to compare inclusions across products in different tiers.

5. The Government's Private Health website could offer consumers the option to view the Hospital Product Tiers table with the clinical categories arranged by regions of the body/body systems. Categories that are subsets of another category could be displayed immediately after the more comprehensive category. For example, the table could list Cataracts immediately after Eye (not cataracts), and Joint replacements immediately after Bone, joint and muscle and Joint reconstructions.

   Disagree. There is a risk this will create more confusion for consumers.

6. The Sleep studies category should be a minimum requirement for the Bronze tier, facilitating access to diagnostic sleep study services for Bronze and Silver products.

   Actuarial analysis for cost impacts is necessary before proceeding.

7. Amend the scope of cover of *Digestive system* and *Hernia and appendix* to note hernias and appendectomies are included in *Digestive system* under Gold, Silver and Bronze products. *Hernia and appendix* is listed as a separate category in Basic Plus products. For Basic Plus products, the Hernia and appendix category should also identify which types of hernias are not covered by the category and are instead covered by the *Digestive system* category.

   Disagree. It could create more confusion. Health funds have various recommendations on how to make this clearer, and we recommend engagement with fund representatives to discuss the best options.

8. Some hernia MBS items in *Digestive system* should be moved to the *Hernia and appendix* category, such as item 30621 for the repair of umbilical, epigastric or linea alba hernias.

   There are mixed views among health funds about this. PHA recommends actuarial assessment to examine costs.

9. Categories where there are no MBS items listed or where the majority of covered services are not in the MBS (such as the dental and podiatric surgery categories), should note in the scope of cover that the category may provide limited benefits.

   Agreed. This will assist consumers to understand the differences between, for example, surgery provided by podiatrists and by medical practitioners.

10. Amend the scope of cover of Gynaecology and Miscarriage and termination of pregnancy to note miscarriage and termination of a pregnancy services are included in Gynaecology under Gold, Silver and Bronze products. Miscarriage and termination of pregnancy services are listed separately in Basic Plus products.

    Disagree.

11. MBS items 14203 and 14206 for hormone or living tissue implantation should be moved to either the *Common treatments list* or the *Support treatments list*.

    There are mixed views among health funds about this.

12. The name of the *Breast surgery (medically necessary)* and the *Plastic and reconstructive surgery (medically necessary)* categories could replace the reference to 'medically necessary' with 'Medicare payable services'.

    There are mixed views among health funds about this.

13. The skin flap MBS items 45201 and 45206 should be moved to the *Skin* category. The volume of services provided following the amendment should be monitored to ensure the items are not being over-serviced.

    There are mixed views among health funds about this.

14. Rename *Weight loss surgery* to 'Weight loss procedures' so that the category better reflects that it covers all weight loss related hospital procedures.

    Agreed.

15. Move spinal cord procedures to the Back, neck and spine category. Amend the scope of cover of the Brain and nervous system category to only cover the brain and peripheral nervous system.

    Agreed.

16. Additional classification systems such as ICD-10, ACHI and DRGs do not relate well to the clinical categories. These should not be added to Schedule 5 of the Complying Product Rules or be used for eligibility checking purposes.

    There are mixed views among health funds about this.

    PHA recommends discussing these issues with health funds, hospitals and consumers to work through preferred options.

17. Coverage of medical admissions should be determined with respect to the scope of cover requirements in subrule 11F(2) of the Complying Product Rules and following the principles in Recommendation 19(ii). Coding systems such as ICD-10 and DRGs may be used in benefit payment determinations if their mapping complies with the requirements in 11F(2).

PHA recommends discussing these issues with health funds, hospitals and consumers to work through preferred options.

18. The Complying Product Rules should be amended to clarify that the scope of cover has primacy over the MBS items. Proposed changes could include:

- clarifying 11F(5)(a) to note hospital treatments involving the provision of an MBS item listed against a particular category in Schedule 5 are only covered if they are used to treat a condition described in column 2 of the table; and
- amending the header of column 3 of the table in Schedule 5 to 'The following MBS items are included in the scope of cover if provided as part of treatment described in column 2 of this clinical category'.

PHA recommends discussing these issues with health fund medical representatives to work through preferred options.

19. The following principles should be applied by stakeholders when determining coverage of a hospital admission:
    - Coverage of an admission goes to the superordinate description of the scope of cover. The MBS items are subordinate to the descriptive scope of cover.
    - Cover should be determined by the diagnosis and intended therapeutic intervention, in good faith, at the point of admission.
    - A single admission may be covered by multiple clinical categories and benefits are payable for all categories included in the policyholder's policy.

PHA recommends discussing these issues with health fund medical representatives to work through preferred options.

20. Health should publish case studies demonstrating how to interpret the regulations for complex admissions such as those in Appendix 5.

Agreed. However, case studies proposed by the report largely reflect the interpretation of hospitals stakeholders. Case studies need more input from health funds. Scenarios need to be based on the information health funds receive at the point of claim.

21. Amend Rule 11G of the Comply Product Rules to only allow *Rehabilitation*, *Hospital psychiatric services* and *Palliative care* categories to offer restricted benefits in Basic Plus products. All other categories in Basic Plus products must be covered on a non-restricted basis.

    Some health funds have significant concerns about this because it will reduce the ability to tailor coverage to the needs of different groups of people and it will not work for products designed to cover people as 'private patients' in public hospitals.

    At the very least, this will require actuarial examination for affected products with affected insurers.

22. Amend Subrule 11H(3) to require all relevant hospital insurance products carry the 'Plus' branding. That is, if the product offers cover for clinical categories above the minimum requirements for that product tier, it is advertised as a 'Plus' product.

    Not supported. This recommendation appears to be more about the marketing of products than the clinical categories, and it should be up to individual funds how they market their products within the current legislative framework.

23. The MBS data file released by MBS Online should include PHI classification information for a more streamlined process to communicate MBS and PHI changes. Health insurers and private hospitals should be consulted in the development of the new data file.

    Some PHA funds support this.

24. Complaints regarding PHI matters which cannot be resolved using current mediation processes should be referred to an independent body with the powers to:
    - receive and arbitrate on disputes relating to PHI business
    - develop a code of conduct for insurers and service providers
    - publish precedents and clarifications on the legislation and regulations
    - publish regular reports on disputes
    - refer advice to Health where legislative amendments may be required to clarify the regulations
    - refer repeat offenders to APRA, AHPRA, ACSQHC and equivalent bodies.

    The disputes resolution framework and establishment of a complaints authority will require further consultation with the broader private health industry.

    Disagree.

    The vast majority of hospital episodes clearly fall within the existing boundaries of clinical categories and this review should address many of the current outliers, leaving only the small cohort of complex cases that need to be managed. We should have enough resilience within the industry to work through these cases collectively.