# Consultation on the Clinical Categories Review Advisory Committee Report

## Overview

The Australian Government Department of Health and Aged Care (department) is currently seeking feedback on the Clinical Categories Review Advisory Committee Report (Report). The Report sets out the evaluation outcomes by the Clinical Categories Review Advisory Committee (committee). Comprised of independent members with different expertise areas, the committee examined the Government reform of the private health insurance products, specifically the introduction of the clinical categories as standardised definitions for the services covered under hospital treatment products.

The committee noted that the clinical categories have assisted consumers to better understand the services covered in their policy and to compare products more easily across the market. There are still areas where the categories could be further simplified or where there can be supplementary work conducted to improve the effectiveness of this reform. These recommendations by the committee are set out in the Report.

This Online Survey has been prepared by the department to facilitate responses to the Report. Stakeholder feedback on each of the recommendations and the broader Report are invited.

The Report contains information based on MBS items and classifications that was current at the time of the review and as endorsed by the Committee in 2022. Note that the hyperlinks to legislation have been removed on page 43 of the Report.

## Why your views matter

The purpose of this consultation is to seek stakeholder and community feedback on the Report's findings and broad direction. Responses to the Online Survey are due by **30 August 2024**. There is also an option to upload a document in addition to your survey responses.

Your feedback will inform consideration of which recommendations should be implemented and how to best implement them.

**Please take the time to read the Report before you complete the survey.** The Report and a copy of the Online Survey questions can be downloaded below.

**Online Survey**

# Recommendations

For most of the recommendations, stakeholders are required to select if they Agree, Neither Agree nor Disagree, or Disagree with the recommendation. There is also a free text box under each recommendation where stakeholders can provide further feedback or supporting information.

For some recommendations that focus on reiterating the policy intent of the clinical categories, it will not provide the option to Agree or Disagree. The department will progress and engage with stakeholders directly involved in implementing the proposed recommendation. The free text box will be available for any other feedback or supporting information.

Factors to address when providing feedback:

- impact on premiums;
- PHI coverage/participation;
- regulatory and administrative burden; and/or
- transition period.

At the end of the survey, there is an option to upload a document in addition to your survey responses.

**Recommendation 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.

**Context:** The committee noted the scope of cover of most categories can be better clarified with a particular focus on more consumer-friendly examples of medical conditions and procedures. Consumers often referred to the name of the category and the examples of common medical conditions whilst insurers often found the definition of a category to be too broad and preferred to use the MBS items to determine coverage.

Agree  Neither Agree nor Disagree  Disagree

*There is a limit of 1000 characters.*

**Recommendation 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.

**Context:** The scope of cover for this clinical category is defined as:

*'Hospital treatment for chemotherapy, radiotherapy, and immunotherapy for the treatment of cancer or benign tumours. Surgical treatment of cancer is listed separately under each body system.'*

How can the definition for the Chemotherapy, radiotherapy, and immunotherapy category be amended to better convey that it covers non-surgical treatment for cancer? Where applicable, should other clinical category definitions indicate that they cover surgical treatment for cancer?

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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

**Context:** The current name of the category is Eye (not cataracts) and there is consumer confusion when their PHI policy also provides cover for the Cataracts category. The department is open to amending the name of the Eye (not cataracts) category and stakeholder feedback is sought regarding their perspectives on this change and any impacts.

Stakeholders were consulted prior to the implementation of the clinical categories. The names of certain clinical categories were derived from feedback received during these earlier consultations.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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.

**Context:** Ear, nose and throat (ENT) and Tonsils, adenoids and grommets (TAG) services are currently listed under separate clinical categories and must be covered by all Bronze, Silver, and Gold tier products. Insurers have the flexibility to offer products that cover both, only one, or neither category for Basic Plus products. Insurers are not permitted to partially cover a clinical category and must cover all services within the defined scope of cover of a particular category.

In instances where only ENT or TAG is covered by a Basic Plus product, the separation of the ENT and TAG services was considered confusing to some consumers. Some complications arising from TAG surgeries are often interpreted by insurers as not within scope of the category and are instead seen as within the scope of ENT. As a result, some consumers have been advised that their treatment is not covered. Feedback is sought regarding: the current stakeholder impact of only ENT or TAG being covered by certain Basic Plus products, the current scope of cover of ENT and TAG and how it can be amended to assist insurer, health care provider, and consumer communications, and the implementation impact of combining clinical categories for certain product tiers only.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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.

**Context:** This is an option to further improve communications material regarding the clinical categories and product tiers and enable consumers to make an informed choice and select an appropriate product for their needs. The Commonwealth Ombudsman, in its capacity as the Private Health Insurance Ombudsman (PHIO), is the agency responsible for the administration of www.privatehealth.gov.au.

The department intends to consult on this recommendation with the PHIO to ensure the sequencing of the clinical categories on the Private Health website is consumer-friendly and best conveys the differences between each category. Stakeholders, such as insurers, who provide information on the clinical categories on their websites and communication materials can sequence the clinical categories as they see fit.

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**Recommendation 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.

**Context:** The Sleep studies category was noted as being unusual as it offers cover for a diagnostic tool that can be used for heart, respiratory and central nervous system conditions. These conditions are covered by other clinical categories and the scope of these categories often include investigative procedures making it unclear which category should cover sleep studies. The proposal requires a redesign of Bronze and Silver products. However, data published by the PHIO at the time of the Review indicates most products currently on the market already cover sleep studies either on a restricted or unrestricted basis. For products that do not currently cover this category or only provide restricted benefits, cover will need to be extended.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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 are 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.

**Context:** Hernia and appendix, and Digestive system services currently listed under separate clinical categories and must be covered by all Bronze, Silver, and Gold tier products. Insurers have the flexibility to offer products that cover both, only one, or neither category for Basic Plus products. Insurers are not permitted to partially cover a clinical category and must cover all services within the defined scope of cover of a particular category.

The separation of hernias and appendectomies from other digestive procedures allows insurers to offer cost-effective services in Basic Plus products. Feedback is sought regarding:

- the current stakeholder impact of only Hernia and appendix or Digestive system being covered by certain Basic Plus products;
- the current scope of cover of these clinical categories; and
- how they can be amended to assist insurer, health care provider, and consumer communications.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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.

**Context:** The original intent of the Hernia and appendix category was to offer cover for inguinal hernias which are relatively simple conditions to treat. More complex hernia services, such as treatment for ventral hernias were mapped to the Digestive system. From a consumer perspective, the distinction between complex and simple hernias is confusing and has led to coverage disputes with insurers.

Currently, some complex hernias are listed under the Digestive system category while other hernia procedures are listed against the Hernia and appendix category. The proposal to move complex hernias into the Hernia and appendix category will simplify the categories for consumers but may have significant impacts on premiums. Feedback is sought on the impact to PHI policy holders and premiums if the coverage of these clinical categories were amended.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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.

**Context:** The MBS items that are listed in the Dental surgery category relate to cleft lip and cleft palate (CLCP) services which are largely reconstructive and also fall within scope of the Plastic and reconstructive surgery category. Despite this, the committee did not find a need to move CLCP items out of Dental surgery.

Where there are no MBS items claimable for a hospital service, subsection 72-1(2) of the *Private Health Insurance Act 2007 (PHI Act)* requires only hospital accommodation benefits to be payable if they meet the requirements of the *Private Health Insurance (Benefit Requirements) Rules 2011* (Benefit Requirements Rules). The committee proposes this information should be more clearly noted in both the Dental surgery and Podiatric surgery categories.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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.

**Context:** Gynaecology and Miscarriage and termination of pregnancy services are currently listed under separate clinical categories and must be covered by all Bronze, Silver, and Gold tier products. Insurers have the flexibility to offer products that cover both, only one, or neither category for Basic Plus products. Insurers are not permitted to partially cover a clinical category and must cover all services within the defined scope of cover of a particular category.

Feedback is sought regarding: the current stakeholder impact of only Gynaecology or Miscarriage and termination of pregnancy being covered by certain Basic Plus products, the current scope of cover of Gynaecology and Miscarriage and termination of pregnancy and how it can be amended to assist insurer, health care provider, and consumer communications, and the implementation impact of combining clinical categories for certain product tiers only. ○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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*.

**Context:** Both MBS items are currently listed under the Assisted reproductive services category but are also relevant to categories covered in lower tier products. To reduce complications during the eligibility checking process, the committee proposed movement of MBS items to either the Common or Support list would increase access to eligible benefits but may increase manual assessments by the insurers. Feedback is sought regarding the impact of this proposed change to premiums, consumers, and/or delivery and administrative factors.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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'.

**Context:** Both the Breast surgery and the Plastic and reconstructive surgery categories provide cover for procedures that are eligible for Medicare benefits. The addition of 'medically necessary' to the name was intended to encapsulate that some procedures also had a psychological aspect. Feedback is sought regarding the amendment to better convey that the scope of cover includes non-cosmetic services and services where a Medicare benefit is payable.

Consider if it is prudent to continue including terms such as 'medically necessary' or 'Medicare payable services'. Additionally, does the presence of this terminology potentially lead to confusion when differentiating from other clinical categories that do not incorporate these terms?

Agree  Neither Agree nor Disagree  Disagree

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**Recommendation 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.

**Context:** Both MBS items are currently listed under the Plastic and reconstructive surgery (medically necessary) category. The committee noted that many MBS items listed under the Plastic and reconstructive surgery (medically necessary) category are used in skin cancer surgery. Movement of these MBS items will increase access to services as the Skin category, which must be covered by all Bronze, Silver, and Gold products.

Agree  Neither Agree nor Disagree  Disagree  -+

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

**Context:** The current scope of cover for 'Weight loss procedure' is hospital treatment for surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of a bariatric procedure. For example: gastric banding, gastric bypass, sleeve gastrectomy.

The proposed clarification is to assist consumers understand the category covers all procedures relating to weight loss. The recommendation should be accompanied with education activities facilitated by insurers on the scope of cover of the category. Feedback from policyholders indicated confusion around the coverage of procedures to remove excess skin following non-surgical weight loss. The committee agreed to retain excess skin removal procedures in the Weight loss surgery category and to amend the name of the category to reflect that it includes all weight loss related procedures.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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.

**Context:** The overlap between the two categories is largely due to spinal cord procedures. The spinal cord is part of the central nervous system and is presently covered in the Brain and nervous system category. However, many spinal cord procedures such as spinal decompression include orthopaedic MBS items. This has caused eligibility checking problems if only one of the categories was included in the patient's policy.

To simplify the Brain and nervous system category, the committee proposed that spinal cord and related services be moved to Back, neck and spine.

Moving spinal cord items will reduce the cost of covering the Brain category (Bronze tier category) and increase the cost of covering the Back category (Silver tier category) for insurers. Consumers with a Bronze product and some consumers with Basic Plus policies will likely lose cover for services. No impacts for silver or gold policyholders.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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.

**Context:** MBS items were chosen as the indicative as they were widely used by insurers which meant an easier adoption of the new definitions, and the items were familiar to consumers. From this perspective these additional codes would be of little benefit for consumers. From an industry perspective, the codes could offer a more simplified system of determining coverage. However, MBS items can have multiple links to different classification systems potentially resulting in codes being applicable to more than one clinical category. This is already a problem with the MBS items where an item may be within scope of multiple categories making eligibility checking processes complicated and resource intensive. Including additional classification systems in the Complying Product Rules may cause more confusion for stakeholders.

This recommendation is advice to the industry and is not a policy change nor does it require any legislative amendments. Feedback is sought from stakeholders who may be using other classifications, other than the MBS, to determine coverage under the clinical categories system. The department will consider broader stakeholder feedback on how to simplify and improve communications relating to the clinical categories and product tiers.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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).

**Context:** The committee agreed DRGs, ICD and ACHI codes do not relate well to the clinical categories and are not appropriate mechanisms to determine private health insurance coverage of services in the private hospital sector. If insurers undertake their own mapping, this information is not a substitute of the clinical categories' scope of cover and should not influence billing and claiming practices.

This recommendation is advice to the industry and is not a policy change nor does it require any legislative amendments. Feedback is sought from stakeholders who may be using other classifications, other than the MBS, to determine coverage under the clinical categories system. The department will consider broader stakeholder feedback on how to simplify and improve communications relating to the clinical categories and product tiers.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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'.

**Context:** Rule 11F sets out the coverage requirements for a hospital insurance policy with Subrule 11F(2) specifically defining the scope of cover of a clinical category. The scope is intended to be inclusive and not limited by the list of MBS items in Schedule 5. However, the practical implementation of the clinical categories has led to many insurers primarily using the MBS items to determine coverage. Interpretations of Subrule 11F(5) has also promoted a view that MBS items are of equivalent importance and the items can be used to determine coverage without regard to the scope of cover.

The recommendation reinforces the policy position of the government since the conception of the clinical categories. The department will engage directly with insurers to reiterate the clinical category regulations.

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**Recommendation 19:** The following principles should be applied by stakeholders when determining coverage of a hospital admission:

i. 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.
ii. Cover should be determined by the diagnosis and intended therapeutic intervention, in good faith, at the point of admission.
iii. A single admission may be covered by multiple clinical categories and benefits are payable for all categories included in the policyholder's policy.

**Context:** This is a statement by the Committee intended to clarify existing coverage requirements. This is advice to the industry on the interpretation of the legislation aimed at assisting in the interpretation of coverage for complex admissions.

MBS items may be relevant to more than one category. Present limitations in insurer claiming software does not support MBS items being placed in more than one clinical category. Items have instead been listed in the category most likely to cover the service or to the category that is a minimum category for lowest applicable product tier. Where an MBS item is within scope but not specifically listed within a category, consumers, private hospitals and clinicians have raised concerns that incorrect eligibility advice is being provided.

The recommendation reinforces the policy position of the government since the conception of the clinical categories. The department will engage directly with insurers to reiterate the clinical category regulations.

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**Recommendation 20:** Health should publish case studies demonstrating how to interpret the regulations for complex admissions.

**Context:** The case studies proposed by the report largely reflect the interpretation of the legislation by hospital stakeholders. This is not necessarily the departments' position and some amendments to the advice in the case studies may be required. The department intends to work with peak bodies, medical colleges, and other stakeholders to ensure the correct interpretation of the legislation and consistent messaging is being delivered to their members.

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**Recommendation 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.

**Context:** Restricted categories may incur out of pocket costs for theatre fees, additional hospital fees, accommodation, and medical costs.

For Gold products, no category can be covered on a restricted basis. For Silver and Bronze products (and related 'Plus' products), only Rehabilitation, Hospital psychiatric services and Palliative care can be covered on a restricted basis. All categories in Basic and Basic Plus products can be covered on a restricted basis. Rule 11G does not prevent some services within a restricted category from attracting unrestricted benefits, as described in the Explanatory Statement for the *Private Health Insurance (Reforms) Amendment Rules 2018.*

Currently, Basic Plus products are able to offer restricted benefits for categories that are above the minimum requirement for Basic policies. This allows insurers the flexibility to offer tailored products to specific cohorts who may not want comprehensive cover for specific services. This recommendation would remove flexibility and can result in consumers facing a large increase in premiums due to services being covered on a non-restricted basis (contracted rates) or losing benefits completely if insurers decided to remove cover for services in an effort to keep the product at a specific price point.

Hospital stakeholders were concerned that consumers are disadvantaged when receiving restricted benefits for services. Feedback is sought on the impact of this change to premiums, product design, coverage, and health service access.

(•) Agree ( ) Neither Agree nor Disagree ( ) Disagree

*There is a limit of 1000 characters.*

**Recommendation 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.

**Context:** Consumer surveys indicate policyholders may not realise their policy offers cover for services above the minimum requirements unless branded as a 'Plus' product. This may cause problems if the consumer switches insurers and the new insurer is also not aware of the coverage of additional categories. This could result in additional waiting periods being imposed that have already been served. In line with improving transparency of hospital insurance products and supporting consumers to make informed choices when comparing products, the committee agreed provisions in 11H(3) should be amended to require consistent naming of 'Plus' products.

Minor policy change with flow on amendments required for the Rules. Currently, insurers have the option of using the 'Plus' branding for products that offer cover above the minimum requirements. It is unclear how many products choose not to carry the 'Plus branding'. Feedback is sought on how many insurers and products will be affected if this change is implemented.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

*There is a limit of 1000 characters.*

**Recommendation 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.

**Context:** This recommendation would require significant system changes within the department to integrate PHI considerations earlier in the MBS item assessment process.

The committee noted early notification and consultation on potential changes to the clinical categories allows the industry to properly assess impacts and provide the department with considered advice supported by evidence. The industry would prefer three months notification prior to the implementation of changes but it is understood this is not always possible. Possible avenues to communicate changes earlier is to include PHI information in the MBS factsheets and MBS data file (.xml file) released by MBS Online. Implementation dates should also consider the time required by stakeholders to update their systems, including updates to Services Australia's Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE).

○ Agree ○ Neither Agree nor Disagree ○ Disagree

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**Recommendation 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.

**Context:** As an extension to the considerations of how the clinical categories are managed, the committee considered the current pathways to resolve conflicts between stakeholders. At present, matters may be referred to different government agencies who have differing powers to investigate and recommend an outcome. For example, disagreements regarding eligibility for benefits under the clinical categories are commonly referred to the PHIO, which has the powers to investigate and mediate conflicts under Part IID of the *Ombudsman Act 1976*; the department provides advice on the interpretation of the legislation; false and misleading behaviour can be raised with the Australian Competition and Consumer Commission (ACCC); and concerns regarding professional conduct or clinical governance may be referred to the Professional Service Review, Australian Health Practitioner Regulation Agency (AHPRA) or the Australian Commission on Safety and Quality in Health Care (ACSQHC).

The department does not intend to progress the recommendation to create a new agency or by adding these responsibilities to an existing agency. Common trends with disputes and concerns raised with the department and other agencies generally relate to misunderstanding the scope of cover and its primacy, and that health care providers have clinical autonomy in providing patient care. In conjunction with other Recommendations aimed at improved stakeholder understanding and engagement, the department will focus on sector education in reinforcing the principles and policy intent of the clinical categories.

○ Agree ○ Neither Agree nor Disagree ○ Disagree

*There is a limit of 1000 characters.*