Dr Margaret Faux (PHD)
SOLICITOR

7 March 2025

The Senate
Standing Committee on Community Affairs
Legislation Committee
Via: online lodgement

RE: Inquiry into the provisions of the Health Legislation Amendment (Improved Medicare Integrity and Other Measures) Bill 2025.

Introduction

Thank you for giving me the opportunity to provide this submission.

This introduction summarises my professional experience and background. I will then address three key areas of relevance to the inquiry that fall within my area of expertise, namely:

i. The likely impact of the proposed reduction in time for the submission of bulk billed claims.
ii. The likely efficacy of proposed new investigative powers in the *Health Insurance Act 1973* (HIA).
iii. What I perceive to be missed opportunities in two important areas:
    a. Supporting Crown Prosecutors to maximise their chances of success, and
    b. Better protection of consumers from out-of-pocket medical costs.

1. I am currently employed as the Chief Executive Officer of a company that runs one of the largest medical billing services in Australia, Synapse Medical Services (Synapse). Synapse administers all types of medical bills for health practitioners across every medical and many allied health specialities, as well as providing medical billing solutions and services to public and private hospitals, large corporate organisations and government agencies. Synapse also provides clinical coding, transcription, and consulting services, which includes a range of health financing and payment integrity projects such as medical billing compliance audits.

2. A related legal entity, The Australian Institute of Medical Administration and Compliance, publishes weekly answers to complex questions submitted by health sector professionals on Medicare and medical billing interpretation.[1] The answers are written exclusively by me.

3. I am a practicing solicitor specialised in Medicare and medical billing law and practice.

[1] https://aimactraining.com/welcome-to-mbs-answer/

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4. I have a PhD on Medicare claiming and compliance. My research examined the Medicare billing system through a legal, administrative and system lens using a mixed methods design. The thesis is publicly available in the UTS online thesis collection.[2]

5. Prior to studying law, I qualified and practised as a registered nurse for over a decade and still maintain my non-practising registered nurse status with the Australian Health Practitioner Regulation Agency.

6. In my capacity as a solicitor, former clinician, and Medicare expert, I regularly receive instructions from law firms to act as an expert in legal proceedings, both civil and criminal, concerning the operation of Medicare and Australia's broader health financing arrangements. I also provide consulting services in various contexts for organisations seeking advice on correct Medicare billing practices. Examples of my current consulting projects are as follows:

    a. I am the expert in criminal proceedings before the District Court QLD which were initiated by the Commonwealth Department of Public Prosecutions against a General Practitioner. The matter is a retrial of alleged fraudulent Medicare billing involving profoundly complex aspects of legal interpretation of Medicare Benefits Schedule (MBS) items and medical billing practices.

    b. I am assisting a legal team who have appealed a Professional Services Review (PSR) decision against a medical practitioner, in the Federal Court.

    c. A university client has engaged me to prepare a detailed report on correct interpretation of a large number of General Practitioner Medicare items and whether such items may be lawfully billed in the context of a new model of care in a remote setting.

7. Synapse operates in international markets doing the same work (medical billing, clinical coding, and health financing consulting) and has various projects in the Middle East and an office in Dubai. I recently led a team who developed the non-admitted casemix classification for the Kingdom of Saudi Arabia.

8. I am regularly asked to comment in the media on the topic of Medicare law and interpretation. This has included featuring in the Sydney Morning Herald, The Age, The Guardian, The ABC, Channel 9, 60 Minutes, and the ABC's 7.30 and 4 Corners.

[2] Medicare claiming and compliance, UTS thesis collection: https://opus.lib.uts.edu.au/handle/10453/155387

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9. I have published over 200 articles, both peer reviewed and popular media, on the topic of Medicare and private health insurance law and billing and contribute widely to Australia's health reform debate.[3]

10. I have an adjunct research appointment at Southern Cross University, New South Wales. My research interests are focused on enabling equitable access to well-functioning Universal Health Coverage systems. My specific areas of interest are directly connected to my four decades of industry experience which has spanned health system financing, payment integrity, codes and classifications, regulation, and digital enablement.

11. I have deep knowledge of the realities of the street in terms of how Medicare is used in the real world having personally administered hundreds of thousands of medical bills over the course of my four-decade career.

Executive Summary

12. While there are some excellent and obviously well-intentioned measures included in this Bill, I am concerned that it is unlikely to achieve its stated objective of improving Medicare payment integrity.

13. There does not appear to be any evidence to support the suggestion that reducing the time frame for bulk billed claims from 2 years to 1 year will reduce fraud. Based on my experience the shorter timeframe is unlikely to have any impact on fraud reduction but is likely to have significant negative downstream consequences. However, a revised approach aligned with international models would have a much greater chance of success.

14. While I do not oppose the proposed new investigative powers, they are unlikely to lead to successful Medicare fraud prosecutions because underlying system problems have not been addressed. Further, the administrative burden associated with investigating claims that often have a small dollar value will not change. As a result, the cost of collection will remain higher than letting incorrect Medicare claims be left stolen from the public purse and the Chief Executive Medicare (CEO) is therefore unlikely to pursue many such claims even in the face of clear evidence that the claims were incorrect. However, if coupled with a new absolute liability offence akin to certain traffic offences, the new investigative powers could be used very effectively.

15. In my opinion the Bill misses an important opportunity to address the needs of both consumers and public prosecutors, the latter of whom will continue to be hamstrung by the requirement to prove serious criminal cases beyond a reasonable doubt. It will remain almost impossible to prove the mens rea element (the criminal mind) of any criminal offence when

[3] My consolidated articles and media appearances are available at this link: https://synapsemedical.com.au/news/category/publications/

no health practitioner is ever taught how Medicare works or how to bill correctly in the first place and evidence of their widespread ignorance of correct Medicare billing is worsening in plain sight. Insofar as consumers are concerned, Medicare integrity and consumer out-of-pocket costs are inextricably linked. This is therefore a missed opportunity to protect consumers from egregious hidden fees that are being charged when they go to hospital.

16. Medicare payment integrity is hugely reliant on successful enforcement. The dearth of Medicare fraud cases against medical practitioners reported on the legal databases demonstrates that Australia has been largely unsuccessful prosecuting Medicare fraud. Continued weak enforcement, while Australians are struggling with a cost-of-living crisis, will erode public trust in the Medicare system and continue to cost the system billions. In my opinion this Bill inadequately addresses the need to achieve successful enforcement of Medicare fraud offences.

<u>The proposal to reduce the time for bulk billed claims from 2 years to 1 year</u>

17. I support reducing the timeframe for submitting claims. However, the current proposal appears to have been arbitrarily decided based on no apparent evidence, noting that data is only one aspect of the evidence required to make these types of decisions. Data shows only that the system is being used. It does not show how or why it was used in the way it was. Data is devoid of context around how billing decisions were made and why a certain MBS item or claim type was chosen, both of which are critically important to understand before making operational changes.

18. The Bill proposes reducing the timeframe for submission of bulk billed claims (but not simplified billing claims), from 2 years to 1 year. I note that Ged Kearney MP stated in her second reading speech that "…most claims are already made within 12 months. There will be discretion to accept claims after that time…" While this may be true on paper, it does not follow that all legitimate claims are paid within 12 months and the exercise of the discretion to extend the time (which already exists) is a fallacy.

19. Services Australia currently takes 12 months to action requests to refund or adjust Medicare claims, so reducing the timeframe to submit such claims to 12 months, without increasing the capacity of Services Australia, will cause problems.

20. I offer the following example of a real claim for $109.10 that took Synapse one year to refund. This is the type of work that medical billers do every day which is never reflected in government data. This was a simplified billing claim, but the process and timeframes are the same for bulk billed claims. All names have been redacted from the table.

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Date	Comments	Notes
15/11/2023	Error made	MBS item 116 billed incorrectly. Service was not provided.
17/11/2023	Payment received	$109.10 received, representing full payment into the doctor's nominated bank account
21/11/2023	Refund request letter sent to Medibank	Medibank confirmed receipt and will liaise with Medicare.
7/12/2023	Follow up	Spoke with rep stated as they have received the reversal letter and sent to medicare for processing, suggested to allow another 1-months for processing
17/01/2024	Follow up	spoke with rep stated as the reversal letter is still in Medicare for processing, suggested to allow another 3-months for processing
15/03/2024	Follow up	TT rep at Medibank said the reversal letter was sent Medicare for processing. Rep said Medicare is behind due to backlogs. She said they will follow up with Medicare and call us back with the status within 5 to 10 business days
21/03/2024	Follow up	TT rep at Medibank said the reversal letter sent to Medicare on 291123. They have spoken to Medicare on 190324. Medicare said they received the reversal letter and it is in queue for processing and currently Medicare is working on April 2023 adjustment and it may take another few months
27/03/2024	Follow up	Called MPL Spoke with rep enquired about the reversal letter status with the , rep did verified and said currently in Medicare for processing, rep said normal time frame for reversal letter it takes 6-8months, suggested to call back after 1-month
2/05/2024	Follow up	TT rep at Medibank said the claim is still with Medicare. Rep said Medicare is 10 months behind so this claim will processed in September 2024
16/05/2024	Follow up	Called MPL Spoke with rep stated as the claim is still with Medicare. Rep said Medicare is 6 months behind so this claim will processed in September 2024
15/07/2024	Follow up	Called MPL Spoke with rep enquired about the status, rep did verified and said the claim is still with Medicare. suggested to allow another 2-months for processing
23/08/2024	Follow up	Called Medicare Spoke with rep enquired about the adjustment status, rep did verified and said still in queue, need to allow another 1-2months for the complete
26/08/2024	Follow up	TT rep at Medibank said the claim was sent to Medicare on 29.1123 and is still with Medicare. Medicare takes 12 months to process the adjustments and said to follow up after 2 months
19/09/2024	Follow up	TT rep at Medibank said still they have not received response from Medicare. Rep said they will follow up and with Medicare and get back us in 2 business days
20/09/2024	Follow up	Received a call from rep from Medibank said Medicare has actioned it today and letter will take 4 weeks approximately to arrive
07/11/2024	Refund initiated	One week shy of a year later, we refunded $109.10. Approximately 60% was returned to the public purse and the balance to Medibank Private. The cost of administering this refund was over $2500

21. This example demonstrates one of the realities at the medical billing coal face which is that it is much harder to give money back to Medicare than it is to get it. The proposed shortened 1-year timeframe fails to consider this and many other challenges that the medical billing workforce deals with daily.

22. Another challenge faced by billers is that once a medical bill hits the current 2-year cutoff date, Services Australia will thereafter refuse to discuss or take any further action on a claim, even if the billers have been working with Services Australia on it for many months. When this happens, Services Australia will advise that we are required to submit a Late Lodgement Form, which is the form used to exercise the discretion that Minister Kearney referred to in her second reading speech. The Late Lodgement Form is yet another onerous administrative task requiring an explanation of why the claim is late. Synapse stopped administering Late Lodgement applications almost a decade ago because:

    a. They never succeed and in fact, we never receive a reply to such applications, and
    b. Very often, the government is the cause of the late claim, and we prefer not to state that on the form.

23. I predict there will be negative downstream impacts felt by this proposal in high bulk billing specialties such as pathology. Synapse administered the rejected pathology claims for one of the largest pathology providers in Australia for many years. The typical size of the arrears buckets we were tasked with clearing was $1 million and the majority of these were legitimate bulk billed claims that had been rejected by Medicare. Many were almost two years old by the time we were able to resolve them. The nature of pathology billing rules, and specifically a rule known as the "Rule 3 Exemption" means that some rejected pathology claims cannot be actioned until many months after the initial claim submission. The combination of a 12-month timeframe to submit (which should be viewed as a hard stop given, in my experience, the discretion to extend is never exercised), Services Australia being 12 months behind in their work, and the Rule 3 Exemption (it has a 6-month time limit), will cause problems for many legitimate pathology claims.

24. Another area that will likely be impacted by the shorter timeframe would be radiology, which is another high bulk billing environment. It should be noted that when claims are not paid and billers are unable to get them paid, providers will immediately shift the outstanding bill to the patient and demand that they pay it instead. This proposal therefore risks increasing patient out-of-pocket costs.

25. I recall that in or around 2007 the timeframe for submitting claims was shortened to 6 months. I recall the negative impacts felt across the industry which led to the timeframe being extended to 2 years. Nothing has changed since then in terms of the manual processes that medical billers are required to undertake and there is therefore no reason to think that

the proposed shorter timeframe will not have the same negative downstream consequences this time.

26. In my experience health practitioners adjust their behaviour very quickly when they encounter new billing barriers. It is my opinion therefore, based on four decades of experience, that a fraudster who currently submits a bucket of claims just before the 2-year cutoff to avoid scrutiny, will simply submit the same volume of fraudulent claims just before a 1-year cutoff.

27. Every day at Synapse our billing team encounters the situation where a Medicare eligible patient's bills are unable to be paid by the expected payer. This could have been a worker's compensation insurer, a private health insurer or someone else. There are numerous complex reasons for this. When this happens, doctors often instruct us to "just bulk bill it", which we do not do because bulk billing without patient consent is illegal, and we do not have patient consent. However, I am aware that most billers will submit bulk billed claims for immediate payment in these circumstances, effectively using bulk billing as a debt recovery mechanism. As an aside, this scenario demonstrates why data alone does not explain why some bulk billed claims are submitted many months after the date of service. It could simply have been because the expected payment methods were tried but failed and bulk billing was used (albeit incorrectly) as a last resort for payment.

28. A shorter timeframe for bulk billed claims derived from the US model would have a greater chance of success in reducing fraud and would also assist in preventing bulk billing being used as a debt recovery mechanism when the common scenario just described occurs.

29. Synapse has experience in the US medical billing system where the time frame for first submission of claims is typically 90 days (some payers allow more time), and the payment cycle is 30 days for most claims.

30. It does not make sense to me that this Bill proposes a 365-day timeframe for a 1-day payment cycle (bulk billed claims are paid overnight), when the US and many countries that use the US billing system have adopted a 90-day timeframe for a 30-day payment cycle.

31. I am not suggesting or recommending that Australia adopts the US medical billing system. It has its own problems. However, in my experience, the requirement to make the first submission within 90 days is effective in preventing some fraud.

32. If the timeframe for the first submission of bulk billed claims was reduced to 90 days, but thereafter claims could remain open allowing billers and Services Australia to work on legitimate claims for however long it takes, the advantages that would flow in the Australian context that I can see, are as follows:

a. Fraudsters who seek to avoid scrutiny would genuinely be deterred. 90 days is close enough to the date of service for medical records to be readily available and the patient's memory to still be reliable.

b. In many instances medical practitioners will be thwarted from using bulk billing as a debt recovery mechanism because 90 days would typically have passed while their billers were trying to get the claim paid via a different mode such as through a worker's compensation process. 90 days would effectively force medical practitioners to decide which claim type they wished to use at the outset rather than changing their minds further downstream.

c. There would be no need to have a discretion to extend submission time which could remain open, as is the case in the US. While most rejected claims are resolved within two years some can take longer. This will take the pressure off billers and Services Australia who could continue working to resolve genuine claims for as long as it takes.

<u>The likely efficacy of proposed new investigative powers</u>

33. The proposed new sections 129AACA and 129AACB of the HIA will allow the CEO to issue a notice requiring a person to give information, a document or a thing. This power will certainly facilitate law enforcement efforts around accessing information, but in my opinion, will do little to improve Medicare payment integrity because underlying problems have not been addressed.

34. A unique feature of fee-for-service payment systems such as our Medicare is that they transact very high volumes of low value claims. This fact is precisely what sets these systems apart from other industries and why fraud and abuse is so hard to detect. The reality is that, as long as a health practitioner bills their lies correctly and doesn't get too greedy, they are unlikely to be caught absent a tip-off. Two or three fraudulent claims per day will usually not raise any red flags and will go unnoticed. If the government is serious about improving Medicare payment integrity, instead of focusing only on statistical outliers (which is the current approach), it must introduce laws to tackle the middle of the bell curve where most fraud exists.

35. One of the challenges in this area has always been that the cost of investigation and recovery outweighs the value of the claim. My earlier example of Synapse incurring costs of over $2,500 to refund a $109 claim is a case in point.

36. Evidence from my PhD research suggested that an effective approach to tackling incorrect Medicare billing could be achieved by delivering quick justice. To be successful, a quick justice model would require a national education program, and the intention of the offender would need to be made completely irrelevant.

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37. The proposed new investigative powers in sections 129AACA and 129AACB of the HIA will enable the CEO to more easily access medical records which will obviously be of benefit in large scale investigations. However, this new power could also be used very effectively if it were coupled with a simple new absolute liability offence. I suggest a new offence could work like this:

    a. Upon the CEO finding that the medical records do not support the MBS item billed, the offence is made out. Just like driving under the influence of drugs where intention is irrelevant – if we drive under the influence of drugs, we are immediately guilty, and no defences are available.

    b. The practitioner would be required to refund the full value of the claim, no matter how small, and pay a 2-commonwealth penalty point fine for every MBS item found to have been incorrectly billed. The current commonwealth penalty point value is $330, meaning a 2 penalty point offence would attract a fine of $660. Given medical practitioners are the highest income earners in Australia (according to the Australian Taxation Office[4]) anything less will not be a sufficient deterrent.

    c. A system like this could be expanded to include a series of increasing penalties in the same way that our drivers' licences work. It should be noted that one of the reasons for successful prosecutions of driving offences is attributable to all Australians having learnt the road rules before they were first allowed to drive. Like our drivers' licences, at a certain point the health practitioner's Medicare billing rights would be revoked and repeat offenders would eventually face jail.

Two missed opportunities

Support for Commonwealth Prosecutors

38. While the proposed new investigative powers in sections 129AACA and 129AACB of the HIA will assist in obtaining relevant records for regulators and law enforcement agencies, they are unlikely to change very much in the court room, certainly not in the context of serious criminal proceedings around Medicare fraud.

39. The dearth of successful prosecutions on the case law databases demonstrates the challenges our Crown Prosecutors have always faced when it comes to prosecuting Medicare fraud. I examined these cases in detail during my doctoral studies and the evidence from my research suggested that without mandatory Medicare education, delivered to medical practitioners before they are granted access to Medicare, successful prosecutions will

[4] https://www.ato.gov.au/about-ato/research-and-statistics/in-detail/taxation-statistics/taxation-statistics-2021-22/statistics/individuals-statistics#Chart5Individuals

remain difficult. Medical practitioners will simply plead ignorance around correct Medicare billing and the evidence suggests that they often are ignorant.

40. In the quantitative phase of my doctoral studies, I conducted a survey of all organisations who had any involvement in teaching medical practitioners about medical billing from their first day as medical students to the end of their careers. The study was published in the BMJ Open.[5] In essence, I asked four questions:

    a) Do you teach medical billing?
    b) Have you ever taught medical billing?
    c) Do you think medical billing should be taught?
    d) If you think medical billing should be taught, who do you think should teach it?

    The results were basically that no-one teaches it, everyone thinks it should be taught, and everyone thinks it is someone else's job to teach it.

41. In the subsequent qualitative phase of my PhD, I interviewed two groups of medical practitioners about their knowledge of medical billing. One group was general practitioners and the second was salaried medical officers working in NSW public hospitals. Most of these medical practitioners were very senior, including department heads, and they all conveyed the same messages of not really having much of a clue about how to bill correctly having never been taught it, and there being no reliable source of information and advice available to them. This research study was published in PLOS ONE.[6]

42. The empirical evidence from my PhD research presents a problem for prosecutors because it means that when a medical practitioner who is under oath says they didn't know that their billing behaviour was wrong, they may be telling the truth.

43. A recent very public example of widespread ignorance by medical practitioners around correct Medicare billing was seen throughout April 2024 after the broadcast of the ABC 4 Corners program titled "Pain Factory" on 8 April 2024. The use of fluoroscopies (a type of x-ray) was featured in the 4 Corners program and an associated online article to demonstrate one area of incorrect billing. On 8 April 2024 social media erupted with medical practitioners saying that Medicare's fluoroscopy items had nothing to do with how long surgery takes. They were all wrong. In fact, there is now an administrative merits review in progress in relation to published misinformation about the fluoroscopy items that remains on the public record.[7] What follows is a summary of the error made by all the vocal medical practitioners, which appears to have also misled the ABC Ombudsman.

[5] Who teaches medical billing? https://bmjopen.bmj.com/content/8/7/e020712
[6] Wading through Molasses https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0262211
[7] https://www.abc.net.au/about/ombudsman/investigation-reports/ombudsman-investigation-report-four-corners-pain-factory/104187836

44. Here are the two Medicare fluoroscopy items (emphasis added):[8]

> 60506
> Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Group applies (R)
>
> 60509
> Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Group applies (R)

45. The plain legal meaning of the two items is clear. Both I and the most senior solicitor of the Commonwealth Government's Medicare regulator, the Professional Services Review Agency, agree on this point. There are two elements described in each item, the first is a fluoroscopy and the second is a surgical procedure. Of those two elements, the only element that can ever last "1 hour or more" (as is legally required when billing item 60509) - so, for example, 3 hours - is the surgical procedure. There is therefore no ambiguity around these items referring to how long the surgery takes not how long the fluoroscopy takes.

46. Further, we know that the fluoroscopy element of these services takes just a few minutes. Two additional components of the fluoroscopy (analysis and reporting) are then added on. The two extra components typically take another one minute and certainly not more than five minutes. Therefore, the total time for the fluoroscopy element of items 60506 and 60509 would rarely exceed 10-15 minutes all-inclusive. There is no dispute here.

47. To suggest that these fluoroscopy items have nothing to do with how long the surgery takes, as the vocal medical practitioners did, effectively means that approximately 80,000 Australians per year[9] are potentially being exposed to at least 55 minutes of continuous fluoroscopic radiation every time an item 60509 service is provided.[10] This is a dangerously high level of radiation that would exceed the maximum levels of human exposure to radiation recorded during the Fukushima nuclear disaster, per hour. Such a suggestion was plainly ridiculous, and wrong. Yet it appears to have been adopted by many, including the ABC Ombudsman, who has publicly acknowledged the existence of differing interpretations and applications of the fluoroscopy billing codes to include the time spent using a mobile image

[8] They can be accessed here. https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

[9] Enter item 60509 into the search box for the number of services provided for this item per year. I used the last financial year. http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

[10] Item 60509 states "1 hour or more" which, when factoring in five minutes maximum for the analysis and report, means that a minimum of 55 minutes of continuous fluoroscopic radiation is delivered to every patient having a 60509 service and it could be more. This would more than likely lead to the deaths of many patients.

intensifier for fluoroscopy, rather than the total duration of the surgical procedure itself. This is misinformation which remains published on the ABC website.

48. The "Pain Factory" example is important because it demonstrates just how widespread Medicare billing ignorance is among medical practitioners, especially given the fluoroscopy items in question are two of the simplest, most clearly drafted items in the entire Medicare scheme. Despite this, many medical practitioners were unable to understand them. This example therefore reinforces what the evidence makes clear. Unless and until mandatory Medicare education that is nationally consistent, independent of government, legally accurate and tied to practitioner registration, is introduced, our Crown Prosecutors will continue to face the same challenges they have always faced around proving the mens rea element of Medicare fraud. It will remain hard to prove something that medical practitioners were never taught. Doctors will simply say they didn't know and will likely get away with it. Therefore, if the government wants to enable enforcement of the new investigative powers that are proposed in this Bill, it must first recognise and act on the evidence that there is an urgent and pressing need for education.

Support for consumers

49. The most recent Australian Prudential Regulation Authority (APRA) Private Health Insurance Statistics[11] state that less than 3 per cent of privately insured Australians pay more than $500 when they go to hospital. This obviously does not align with the experiences of many Australians who report that they pay exorbitant out-of-pocket fees when they go to hospital.

50. The only explanation for the cavernous gap between what the APRA statistics report and the reality on the ground is hidden fees. A good example of this was reported in The Age[12] late last year. The story reported hidden illegal fees of up to $5,000 being charged by anaesthetists and surgeons to the residents of the Mornington Peninsula in Victoria. In my experience this practice is widespread across Australia.

51. I received a copy of the letter that was reported in The Age and subsequently, I have received more letters from people living and working on the Mornington Peninsula who have provided incredibly detailed information, including the names of doctors and patients, about egregious hidden fees. Here are some quotes from the letters I have received.

    "There is a Mafia like Cartel going [on] down here"

    "I am shocked that such bad criminal practices is allowed to go on for so long unchecked."

    "How is this different from stealing money from the local 7 eleven store?"

[11] https://www.apra.gov.au/quarterly-private-health-insurance-membership-and-benefits-summary-december-2024
[12] https://www.theage.com.au/national/victoria/whistleblower-alleges-widespread-fraud-by-dozens-of-double-dipping-specialist-doctors-sparking-probes-20241113-p5kq5h.html

"I hope they [the surgeons and anaesthetists] go to jail like the rest of us if we steal money from our neighbours..."

"If only the people of Mornington knew how entitled and corrupt this group of Surgeons and Anaesthetists are."

"I do hope the minister of Health would step in and show some leadership and drain the swamp. We need your help. PLEASE HELP."

"Please save the people of mornington."

52. Hidden fees not only hurt patients financially and cause the APRA data to be inaccurate, but they also rob patients of their Medicare safety net entitlements. In a cost-of-living crisis every patient needs their safety nets especially our most vulnerable who may be going through a long cancer journey or have a chronic disease. Any fee that the government cannot see is not counted towards safety nets. Put another way, hidden fees mean many patients miss out on their safety net entitlements and therefore pay more to see the doctor.

53. This Bill presents an opportunity to do something about this and provide consumers with the help they want and need. I therefore urge the government to consider amending section 20A(3) of the *Health Insurance Act 1973* in this round of amendments. Consumers need the government to step up here and legislate to stop hidden fees (often called administration, booking or facility fees). I suggest amending section 20A(3) to operate similarly to bulk billing[13] whereby the Medicare benefit for simplified billing claims would not be payable if the patient has paid a hidden fee.

Thank you again for giving me the opportunity to make this submission. I would like to conclude by saying that successful enforcement is the key to Medicare payment integrity. Without it, public trust in the Medicare system will continue to erode and the cost to taxpayers from Medicare fraud will remain in the billions.

I would be happy to offer any further assistance to the inquiry as required.

Dated 7 March 2025

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[13] See Department of Health and Aged Care education brochure.
https://www.health.gov.au/sites/default/files/2023-10/medicare-bulk-billing-and-additional-charges.pdf