Australian Government

Department of Health

Submission to the Senate Community Affairs Legislation Committee for the Inquiry into the *Health Insurance Amendment (Safety Net) Bill 2015*

Summary

The *Health Insurance Amendment (Safety Net) Bill 2015* implements the 2014-15 Budget measure *Simplifying Medicare safety net arrangements* to reform and streamline the Medicare safety net, making it simpler, less inflationary and more progressive.

The design of the new Medicare safety net is evidence-based. It is informed by analysis of current Medicare data and underpinned by the findings of two independent reviews of the Extended Medicare Safety Net. The new Medicare safety net introduces a new threshold for singles and places uniform caps on the amount of out-of-pocket costs which can accumulate to the eligibility threshold as well as the total benefits payable for all Medicare Benefits Schedule (MBS) services.

Simpler
The streamlining of the three current arrangements (Greatest Permissible Gap rule - GPG, Original Medicare Safety Net - OMSN and Extended Medicare Safety Net - EMSN) into a single Medicare safety net will provide clarity to patients about eligibility and amounts to be returned.

The new Medicare safety net responds to consumer experience with the safety net eligibility rules for families through streamlining arrangements including:

- the process for registering and confirming families, including online applications;
- couples living apart due to one of them being in a nursing home will be treated as a family; and
- dependent children in the 16 – 25 age bracket who temporarily leave full-time study due to ill health can be treated as part of the same safety net family as their parents.

The new Medicare safety net will also provide better support for sick children, especially following a change in family composition.

Less inflationary
The 2009 independent review of the EMSN identified that the EMSN had led to rapid fee inflation in some areas of the MBS, with considerable leakage of Government benefits towards providers' incomes rather than reduced costs for patients.[1] The introduction of safety net benefit caps for all MBS items is expected to have a moderating effect on fee inflation, as demonstrated after the introduction of capping on obstetrics and other services, such as eye injections.

The 2009 review also found that one of the main incentives for fee inflation was the ability for people to cross the threshold of the EMSN in a single high fee service. The new Medicare safety net will respond to this issue by introducing a cap on the amount per service that can count towards the threshold.

Redistribution of benefits
The 2009 and 2011 reviews found that most EMSN benefits have flowed to patients living in relatively higher income areas. Analysis of current Medicare data confirms that this distribution has persisted. The existing safety nets also provide relatively poor access for

[1] Centre for Health Economic Research and Evaluation, (2009) *Extended Medicare Safety Net Review Report 2009*, Canberra.

non-concessional single people on low incomes, particularly people below retirement age who do not have children. A much smaller proportion of single people without concession cards qualify for the EMSN than any other group.

The new Medicare safety net introduces a new threshold for single people and lower thresholds more generally, which means that more people are likely to qualify for safety net benefits. The Department estimates an additional 53,000 people will receive a safety net benefit. The number of eligible concession card holders is expected to increase by 80,500. The number of non-concession card holders is expected to decrease by 27,500.

Overall, this means there will be a relative shift towards concessional access and increased access for single people without concession cards. In addition, it is expected the accumulation benefit arrangements will mean the proportion of benefits flowing to people currently charged up to 150 per cent of the current MBS Fee will increase, meaning a greater share of safety net benefits for those in lower socioeconomic areas.

Impact on patient benefits
People who are charged well above the MBS Fee will notice changes to their Medicare safety net benefits. Much attention has been directed toward the specific impact of these changes on radiation oncology, psychiatry, and Assisted Reproductive Technology (ART) services, given existing billing practices. Further analysis is contained in this submission on these areas. The Department's analysis is based on current billing practices and actual Medicare data. That is, it assumes no change in current practices for analysis only, although the Department does expect that billing practices will change as a result of the Bill. This is based on previous experience with capping.

1. Introduction

The *Health Insurance Amendment (Safety Net) Bill 2015* ('the Bill') implements the 2014-15 Budget measure *Simplifying Medicare safety net arrangements*. It introduces a single Medicare safety net from 1 January 2016 to replace the existing complicated Medicare safety net arrangements. The savings from this Budget measure were estimated at $266.7 million over the Forward Estimates period (2013-14 to 2017-2018).

On 12 November 2015, the Bill was referred to the Senate Community Affairs Legislation Committee for inquiry and report by 23 November 2015.

This submission makes reference to the outcomes of two independent reviews of the EMSN. These reports were prepared by the Centre for Health Economics Research and Evaluation at the University of Technology, Sydney, following open tender processes. The *Extended Medicare Safety Net Review Report 2009* was a review of the whole EMSN. The *Extended Medicare Safety Net Review of Capping Arrangements Report 2011* evaluated the introduction of caps on benefits payable through the EMSN. Copies of the report can be viewed at www.health.gov.au.

1.1 Medicare and the MBS

Medicare was introduced in 1984 as a universal system with the goal of providing Australians with affordable, accessible and high-quality health care. Services under Medicare include:

- fully or substantially subsidised out-of-hospital (non-admitted) services provided by private practitioners such as General Practitioners (GPs), specialists, optometrists and, in specific circumstances, dentists and other allied health practitioners;
- subsidised private patient hospital services;
- fully subsidised hospital treatment for public patients in public hospitals; and
- fully or substantially subsidised medicines through the Pharmaceutical Benefits Scheme (PBS).

The Medicare safety net arrangements apply to out-of-hospital (non-admitted) services only.

Principles of Medicare

Medicare is based on the principle of universal access, meaning everyone is entitled to Medicare benefits regardless of their income. Australian taxpayers contribute to the cost of Medicare through taxes, including a Medicare levy and an additional surcharge for people on higher incomes. Medicare is a system for the payment of patient benefits, not a remuneration system for doctors. One of the fundamental aims of Medicare is that services for which a Medicare benefit is payable should provide a health benefit and value for money.

The Medicare Benefits Schedule (MBS)

The MBS is a key component of the Medicare system. It lists services relevant to out-of-hospital services provided by private practitioners (e.g. GPs, specialists, optometrists) and private patient hospital services for which a benefit is payable, and allocates a unique item number to each service, along with a description of the service. In broad terms, the types of services on the MBS include consultation and procedural/therapeutic (including surgical) services, as well as diagnostic services (e.g. x-rays, ultrasounds and blood tests). Full details of all MBS items, including numbers, descriptors, fees and Explanatory Notes are available from www.mbsonline.gov.au.

Subsidies for services by eligible health professionals take the form of Medicare benefits paid to the patient. The MBS sets out the 'MBS Fee' for each service and the rate/s at which the benefit for that service is to be calculated. It also gives advice on the clinical and administrative conditions under which benefits can be claimed. The rates of benefit are:

- 100 per cent of the MBS Fee for GP services;
- 85 per cent of the MBS Fee for other out-of-hospital services; and
- 75 per cent of the MBS Fee for in-hospital services for private patients.

The MBS Fee is a fee-for-service amount set by the Australian Government, and may differ from the provider's actual fee. The Government has no power to control the amount doctors charge for their services. The patient must pay for any difference between the MBS benefit for a service and the actual fee charged by the doctor. This difference is known as an 'out-of-pocket' cost. Where the health professional accepts the patient's Medicare benefit as full payment for the service, there is no out-of-pocket cost to the patient. This is known as bulk-billing.

2. Health Insurance Amendment (Safety Net) Bill 2015

The Bill will cease the EMSN, OMSN and GPG rule and create a new Medicare safety net.

Key features of the new Medicare safety net

- The new Medicare safety net will continue to cover out-of-hospital services (i.e. those paid at either 85 per cent or 100 per cent of the MBS Fee) and operate on a calendar year basis.
- Subject to any upper limits on safety net benefits payable, safety net benefits will be calculated at 80 per cent of out-of-pocket costs.
- Three thresholds levels, commencing at the following amounts (indexed by the CPI on 1 January each year thereafter):
    - $400 for concessional singles;
    - $700 for non-concessional FTB(A) families and confirmed singles; and
    - $1,000 for all other families and unconfirmed singles.

  The existing EMSN thresholds are $638.40 for concession card holders and Family Tax Benefit Part A recipients and $2000 for all other people and the OMSN threshold is $440.80.
- An 'accumulation cap' will limit the amount of out-of-pocket costs which can accumulate to the eligibility threshold. The accumulation cap will be equal to the difference between 150 per cent of the MBS Fee and the basic Medicare benefit.
- A 'benefit cap' will apply to all MBS services. The benefit cap will be equal to the difference between 150 per cent of the MBS Fee and the basic Medicare benefit. This means the total benefits payable for a service (basic Medicare benefit plus the safety net amount) cannot exceed 150 per cent of the MBS Fee. See Attachment A for examples.

General operation and assisting families

- The definition of a spouse will include couples who are living apart because of illness or infirmity.
- The definition of a dependent child will include a student aged 16-25 years who is temporarily unable to study full time due to illness or infirmity.
- The treatment of families where some, but not all members of a family have a concession card will be simplified. There will be a single accumulation of out-of-pockets. Once the combined total reaches the concessional threshold, all concessional members will qualify.
- Families can actively register with the Department of Human Services (DHS) to pool their out-of-pocket costs as a safety net family. The process for registering and confirming families with DHS will be simplified, including online applications.
- A dependent can be registered as part of one or more safety net families at any point in time. Where a dependent is part of one or more registered families, the out-of-pocket costs accumulate to whichever family incurred the expense.
- If any person in a registered family receives FTB(A), then the whole registered family is given access to the FTB(A) threshold.
- The new safety net introduces a new (lower) threshold for single people without a concession card. Single people must confirm that they are single before they are eligible for this threshold.
- When parents separate before a registered family reaches the Medicare safety net threshold, the out-of-pocket costs of the dependents, up to the date of separation, will be included on both family registrations.
- Children in two families may qualify in their own right for safety net benefits on the basis of services rendered to the child, regardless of which family paid.

3. Current safety net arrangements

There are currently two safety nets – the OMSN and the EMSN – to assist patients with out-of-pocket costs for out-of-hospital Medicare services. In addition, there is the GPG rule, which increases the out-of-hospital rebate for items with a high MBS Fee.

This submission deals largely with the EMSN, rather than the OMSN or GPG. The OMSN is a minor feature of the Medicare system and its expenditure has remained consistent. In comparison, the EMSN has led to fee inflation and is a more significant component of Medicare expenditure. The safety net arrangements have been added to the MBS over time and multiple changes have been made to each of the arrangements. This has resulted in overlapping programmes which are complex and confusing for patients and providers to understand. One, two or all three of the OMSN, EMSN and GPG can apply to the rebate calculations for an MBS item. The interactions between the arrangements can make it difficult for patients and providers to know with certainty the amount of the MBS rebate.

Table 1: Key differences between the existing safety net arrangements

	GPG	OMSN	EMSN
Qualification method	Applies to all out-of-hospital services with an MBS Fee higher than $530	Caps on accumulation – the 'gap' between MBS Fee and 85% benefit	No limit on the amount which accumulates
Benefits	Instead of paying 85% of the MBS Fee – the rebate is calculated at MBS Fee - $79.50 (the maximum gap)	Cap on benefit – limited to the gap (i.e. 15% of MBS Fee)	80% of out-of-pocket costs Caps on benefits for some items
Thresholds	All items with an MBS Fee above $530 automatically have the out-of-hospital rebate increased.	One threshold (2015) $440.80	Two threshold amounts (2015) Concession card holders $638.40 FTB(A) families $638.40 Non-concessional singles $2,000 All other families $2,000

2.1 Greatest Permissible Gap

The GPG is a rule which sets a maximum on the 'gap' – which is the difference between the MBS Fee and the out-of-hospital rebate. The rebate for out-of-hospital services is generally 85 per cent. However, if the difference between 85 per cent of the MBS Fee and the MBS rebate exceeds the GPG, then the out-of-hospital rebate is increased. The GPG amount from 1 November 2015 is $79.50. The GPG is indexed each year by the Consumer Price Index (CPI). Any service with an MBS Fee greater than $530 will have its rebate increased to the MBS Fee less the GPG.

Figure 1 illustrates the operation of the GPG – where the MBS Fee is $2,000, 85 per cent of the MBS Fee is $1,700, and the difference between the Fee and the calculated 85 per cent rebate is $300. As this 'gap' is more than $79.50, the MBS rebate is increased to a value of $2,000 minus $79.50. The GPG pre-dates the OMSN and EMSN.

Figure 1: Greatest Permissible Gap Example – 2016

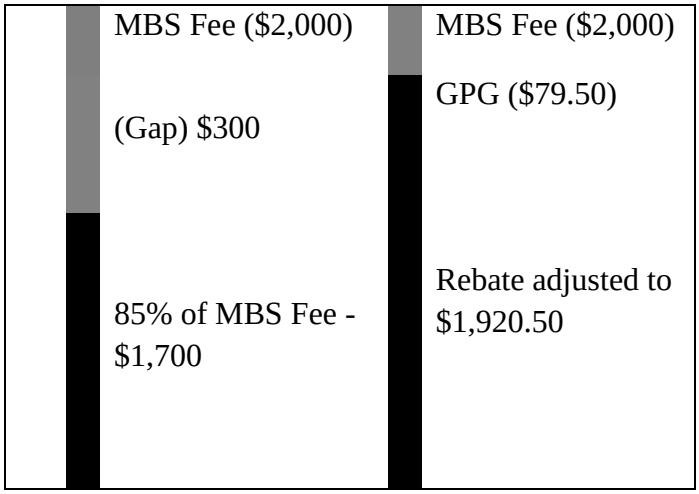


Table 2: Timeline of changes to the Greatest Permissible Gap (GPG)

Year	Introduction / Changes
1974	Medibank introduced with GPG of $5, indexed in November
1984	Medicare introduced with GPG of $10
1986	Increased the GPG to $20
1996	Increased the GPG to $50
1997 - 2015	Indexation increases the GPG to $79.50

2.2 The Original Medicare Safety Net

The OMSN was introduced in 1984 as an individual safety net. It was changed to a family safety net in 1991. In 2015 the OMSN threshold is $440.80. The threshold is indexed each year by the CPI. The OMSN threshold will be increased to $447.40 on 1 January 2016 if the Bill is not passed.

The OMSN covers the difference between the MBS Fee and the MBS rebate (usually 85 per cent of the MBS Fee), known as the 'gap'. When a person or family's accumulated 'gap' payments for out-of-hospital services in a calendar year reach the threshold, the MBS rebate for all further eligible medical services will be increased to 100 per cent of the MBS Fee. A feature of the OMSN is that because accumulation and safety net benefits are linked to the MBS Fee, people generally have to have a high number of services, or services with high MBS Fees, to qualify for safety net benefits. The OMSN is calculated prior to the EMSN. As the MBS Fee and the MBS rebate for GP services is the same, OMSN benefits are not payable for GP services.

Table 3: Timeline of Original Medicare Safety Net (OMSN)

Year	Introduction / Changes
1984	Introduction of OMSN for individuals, indexed in January
1991	Introduction of families threshold for OMSN

2.3 The Extended Medicare Safety Net

The EMSN provides benefits in addition to the standard Medicare rebate for families and singles who have out-of-pocket costs for Medicare eligible out-of-hospital services, once an annual threshold in out-of-pocket costs has been met. Out-of-pocket costs are the difference between the doctor's charge and the standard Medicare rebate. Out-of-hospital services which are eligible for EMSN benefits include GP and specialist attendances and services provided to non-admitted patients in private clinics.

Once a person or registered family has met the relevant annual EMSN threshold in out-of-pocket costs, Medicare will pay 80 per cent of any future out-of-pocket costs for Medicare eligible out-of-hospital services for the remainder of the calendar year. Around 570 MBS items have a maximum safety net benefit or 'cap' in order to limit the incentive for providers to charge high fees for these items.

Since its introduction there have been two EMSN thresholds: the concessional (or lower) and the general (or upper) threshold. Both the upper and lower thresholds are indexed by the CPI on 1 January each year. The EMSN operates on a calendar year basis. All accumulated out-of-pocket costs are reset to zero on 1 January each year. EMSN benefits paid to patients and family members vary from year to year and depend on individual circumstances.

In 2015 the EMSN thresholds are:

- **$638.40** for Commonwealth concession cardholders, and people who receive Family Tax Benefit (Part A); and
- **$2,000** for all other families and singles, as announced in the 2013-14 Budget (up from $1,248.70 in 2014).

Table 4: Timeline of changes to the Extended Medicare Safety Net (EMSN)

Year	Introduction / Changes
2004	Introduction of EMSN, thresholds of $300 (lower) and $700 (general)
2006	Thresholds increased to $500 and $1,000 respectively
2010	Capped benefits for obstetrics, ART and selected other services
2012	Capping extended to all consultation items and some selected items
2015	Upper threshold increased to $2,000

The EMSN was introduced in March 2004 with thresholds of $300 and $700. The EMSN thresholds were increased on 1 January 2006 to $500 and $1,000. EMSN benefit caps were introduced on 1 January 2010 for obstetrics, ART, hair transplantation for alopecia, one varicose vein item and cataract surgery. Caps were set as fixed dollar amounts and can only be increased through a specific approval of both Houses of Parliament.

Caps were expanded on 1 November 2012 to a range of other items; in some cases these were necessary as doctors sought to avoid the caps on varicose veins and cataract surgery. Caps were also introduced for all consultations. This was to address outlier behaviour – for example, doctors charging $6,000 for a GP consultation. The caps were set as a percentage of the MBS Fee. Some caps have also been introduced for new MBS items based on the recommendations of the Medical Services Advisory Committee (MSAC). In a number of cases, the Committee has expressed concern about potential fee charging practices, and that

funding was not cost-effective unless there was a limit on the EMSN, due to concerns that providers may charge fees in excess of the MBS rebate.

Despite these changes, EMSN expenditure for uncapped items continued to increase significantly. The general threshold was increased to $2,000, which came into effect on 1 January 2015. The fee charged in some areas continues to increase. Although the EMSN assists patients in paying for 80 per cent of their out-of-pocket costs, in its current form, the EMSN is still driving fee inflation. As noted in the 2009 independent review of the EMSN, this can lead to an increase in patient out-of-pocket costs. The EMSN thresholds will increase to $647.90 and $2,030 on 1 January 2016 if the Bill is not passed.

4. Expenditure under the current safety nets

Original Medicare safety net

Expenditure under the OMSN is relatively stable. This is because both the accumulation to the threshold and the benefits paid once the threshold is reached are limited. In 2014, people received $15 million in OMSN benefits (representing 3.4 per cent of total Medicare safety nets expenditure).

Table 5: OMSN expenditure since 2004

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
OMSN expenditure ($, million)	$9.4	$8.5	$9.5	$10.9	$12.0	$12.9	$14.2	$14.9	$15.5	$15.4	$14.9
(%) change from previous year		-10.2	12.6	14.9	10.0	7.2	9.8	5.4	4.0	-0.7	-3.6

Extended Medicare Safety Net

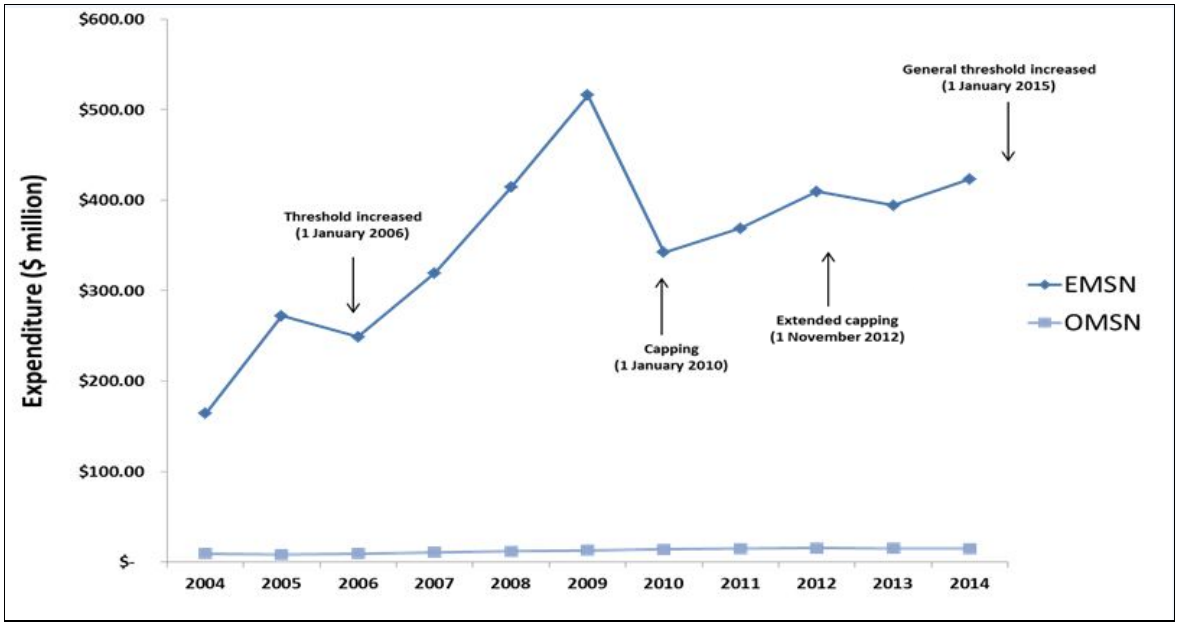
Until 2010, there was no limit on the amount of safety net benefits paid through the EMSN. The EMSN covered 80 per cent of the out-of-pocket cost incurred by the patient for any out-of-hospital Medicare funded service. Expenditure was growing by around 30 per cent or $100 million per annum prior to the introduction of caps on selected MBS items (obstetrics, ART, a cataract surgery item, and hair transplantation for the treatment of alopecia).

EMSN expenditure was expected to reduce in 2015 due to increases in the amount of out-of-pocket costs people without concession cards, or who are not eligible for Family Tax Benefit (Part A) benefits, must incur prior to qualifying for EMSN benefits. However, in some areas, expenditure is continuing to increase rapidly as a result of increases in the fees charged by providers.

Table 6: EMSN expenditure since introduction

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
EMSN expenditure ($ million)	$164.4	$272.2	$248.9	$319.3	$414.1	$516.2	$342.2	$369.0	$409.4	$394.1	$423.5
% change from previous year		63.5	-8.8	28.6	29.7	24.7	-33.7	7.8	10.9	-3.8	7.5

Figure 2: EMSN and OMSN expenditure since 2004 (noting programme changes)

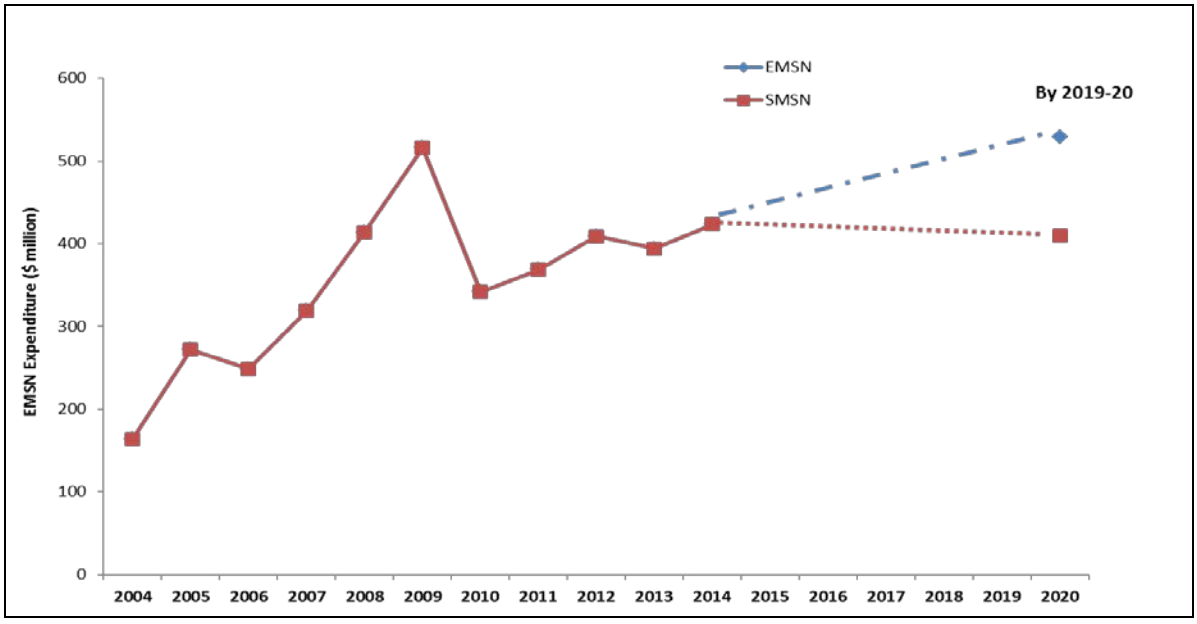


Projected expenditure

Even with EMSN benefits caps in place for around 570 MBS items, EMSN expenditure continues to increase. By 2019-20 it is estimated that EMSN expenditure will be at the same level as before capping was introduced. Some of the growth is driven by fee growth in selected uncapped items, and billing practices which shift around capped items.

The new Medicare safety net will reduce the rate of growth that is driven by fee inflation as there will be universal capping across all MBS items. As a parameter which flows through to the safety net, the impact of the indexation freeze (on MBS Fees for all services provided by GPs, medical specialists, allied health and other health practitioners) is already included in the Forward Estimates.

Figure 3: Projected EMSN expenditure compared to expenditure under the new Medicare safety net



5. Distribution of EMSN benefits

Past reviews of the EMSN have found that there is an inequity in the distribution of EMSN benefits across geographical areas, including by remoteness areas and based on socio-economic index for areas (SEIFA).

Geographic area

The safety net benefits paid in some geographic areas are significantly higher than in others. This is a reflection of different patterns of service use, as well as the tendency of doctors working in higher socio-economic areas to charge higher fees, particularly for people without concession cards. The table below provides information on the EMSN benefits paid by Statistical Area 4 (SA4) region which is used by the Australian Bureau of Statistics.[2]

Table 7: EMSN benefits paid by SA43 region, 2013-14

SA4 Region	EMSN benefits (2013-14)	SA4 Region	EMSN benefits (2013-14)	SA4 Region	EMSN benef (2013-14)
NSW	**$140.21 M**	**Victoria**	**$102.68 M**	**Queensland**	**$78.59 M**
North Sydney and Hornsby	$23.02 M	Melbourne - Inner South	$16.48 M	Brisbane Inner City	$13.86 M
Eastern Suburbs	$15.28 M	Melbourne - Inner	$13.68 M	Gold Coast	$9.72 M
Northern Beaches	$10.95 M	Melbourne - Inner East	$10.95 M	Brisbane - South	$5.82 M
Inner West	$9.62 M	Melbourne - South East	$9.9 M	Moreton Bay - South	$5.51 M
Inner South West	$7.85 M	Melbourne - Outer East	$9.53 M	Brisbane - East	$4.48 M
Ryde	$6.68 M	Melbourne - West	$8.45 M	Sunshine Coast	$4.36 M
City and Inner South	$6.65 M	Melbourne - North East	$7.46 M	Ipswich	$4.32 M
Sutherland	$6.11 M	Mornington Peninsula	$6.53 M	Fitzroy	$4.08 M
Parramatta	$6.03 M	Melbourne - North West	$6.1 M	Wide Bay	$3.62 M
Newcastle and Lake	$6.02 M	Geelong	$4.41 M	Brisbane - North	$3.1 M
South West	$4.11 M	Hume	$1.69 M	Logan - Beaudesert	$2.97 M
Outer West and Blue	$3.6 M	Latrobe - Gippsland	$1.68 M	Toowoomba	$2.85 M
Blacktown	$3.16 M	Shepparton	$1.67 M	Mackay	$2.72 M
Hunter Valley exc	$3.11 M	Warrnambool and South	$1.51 M	Townsville	$2.63 M
Central Coast	$3.02 M	North West	$1.04 M	Moreton Bay - North	$2.33 M
Richmond - Tweed	$2.98 M	Ballarat	$0.92 M	Brisbane - West	$2.18 M
Baulkham Hills and	$2.91 M	Bendigo	$0.69 M	Cairns	$1.86 M
Illawarra	$2.77 M			Darling Downs - Maranoa	$1.49 M
Riverina	$2.22 M	**Western Australia**	**$38.53 M**	Queensland - Outback	$0.55 M
Southern Highlands and	$1.99 M	Perth - North West	$12.68 M		
Outer South West	$1.79 M	Perth - South West	$8.17 M	**South Australia**	**$18.23 M**
Central West	$1.53 M	Perth - South East	$6.26 M	Adelaide - North	$4.11 M
Capital Region	$1.5 M	Perth - Inner	$3.61 M	Adelaide - South	$4.04 M
New England and North	$1.41 M	Perth - North East	$2.83 M	Adelaide - West	$3.66 M
Mid North Coast	$1.26 M	Bunbury	$1.47 M	Adelaide - Central and Hills	$3.64 M
Coffs Harbour - Grafton	$1.16 M	WA - Wheat Belt	$1.4 M	SA - South East	$1.52 M
Far West and Orana	$0.91 M	WA - Outback	$1.13 M	Barossa - Yorke - Mid North	$0.76 M
Murray	$0.76 M	Mandurah	$0.97 M	SA- Outback	$0.49 M
Hume	$0.69 M			SA - South East	$0.01 M
Darling Downs - Maranoa	$0.06 M	**Tasmania**	**$4.5 M**		
North West	$0.02 M	Hobart	$2.2 M	**Northern Territory**	**$1.03 M**
		Launceston and North East	$1.06 M	Darwin	$0.91 M
ACT	**$9.35 M**	South East	$0.68 M	NT - Outback	$0.12 M
ACT	$9.35 M	West and North West	$0.56 M		

[2] An SA4 region is a geographical areas defined by the ABS with a population of between 100,000 and 500,000 people. There are 88 SA4 regions that cover the whole of Australia without gaps or overlaps. In regional areas, SA4s tend to have populations closer to the minimum (100,000 - 300,000). In metropolitan areas, the SA4s tend to have larger populations (300,000 - 500,000).

Regional areas

EMSN benefits are largely directed towards people living in capital cities. Patients in major cities receive both more total EMSN benefits and more benefits per patient.

Table 8: EMSN benefits paid by Remoteness area ($, million) 2014

Remoteness Area Name	Total MBS benefits $m	EMSN* $m	% of total EMSN spend	EMSN as % of MBS benefits
Major Cities of Australia	$14,418	$351.27	82.9%	2.4%
Inner Regional Australia	$3,728	$49.77	11.8%	1.3%
Outer Regional Australia	$1,598	$19.03	4.5%	1.2%
Remote Australia	$181	$2.24	0.5%	1.2%
Very Remote Australia	$90	$0.94	0.2%	1.0%
Unknown[4]	$5	$0.29	0.1%	6%
Total	$20,021	$423.54	100.0%	2.1%

Socio-economic index of areas

As noted in the reviews of the EMSN tabled in Parliament in 2009 and 2011, EMSN benefits are disproportionally directed towards people living in higher socio-economic areas, as they generally have higher out-of-pocket costs for out-of-hospital services funded through the MBS. Areas that have higher bulk-billing rates have fewer out-of-pocket costs. The new Medicare safety net will increase the number of concessional patient receiving safety net benefits.

Table 9: EMSN benefits paid by SEIFA decile, 2013-14 ($, million)

SEIFA decile[5]	**EMSN expenditure 2013-14**	**% of EMSN Expenditure**
1- Least advantaged	$9 M	2.2%
2	$15 M	3.8%
3	$15 M	3.9%
4	$20 M	5.1%
5	$24 M	6.0%
6	$34 M	8.7%
7	$36 M	9.2%
8	$44 M	11.3%
9	$76 M	19.4%
10 – most advantaged	$120 M	30.4%

[4] Where no remoteness area can be allocated e.g. where responses to questionnaires have been filled in illegibly.
[5] Socio-Economic Indexes For Areas (SEIFA) is an ABS categorisation that ranks every geographic area in Australia based on the relative 'disadvantage' of the population of that area. Decile "1" is the most disadvantaged group and "10" the most advantaged. SEIFA deciles are based on areas rather than populations, and therefore the number of people in each group can vary.

The table above shows that over 30 per cent of EMSN benefits went to people living in the most advantaged areas of Australia (SEIFA decile 10) whilst only 2 per cent of EMSN benefits went to people living in SEIFA decile 1 (the most disadvantaged area). Over 60 per cent of EMSN benefits went to SEIFA areas 8 to 10. It should be noted that the SEIFA index is based on the patient's Medicare enrolment postcode. Where the majority of a postcode area falls within a SEIFA boundary, the postcode is allocated to that SEIFA category. The number of people in each SEIFA category is not equal. More information on SEIFA can be found at: http://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa.

6. Distribution of EMSN benefits by service groups

The table below shows expenditure through the EMSN by each broad type of service. The highest growth areas are specialist attendances and radiotherapy cancer treatment. ART continues to be the service group that attracts the most EMSN benefits.

Table 10: EMSN benefits by service group, 2011 to 2014

Service type	**EMSN Expenditure ($, million)**				**2014 MBS Expenditure**	**2014 Percentage of EMSN Expenditure**	**2014 EMSN income as proportion of MBS (benefits) revenue**
	2011	**2012**	**2013**	**2014**	($, million)	(%)	(%)
Assisted Reproductive Technology services	73.6	80.9	83.1	82.5	242.6	19.5	34
Radiotherapy	23	25.9	29.7	44.2	327.9	10.4	13.5
Obstetrics	24.7	25.8	25.5	25	200.6	5.9	12.5
Psychiatry	23.9	26.4	29.6	32.8	327.6	7.7	10
Specialist attendances	33.8	37.6	40.9	44.6	633.6	10.5	7
Allied Mental Health	14.7	15.5	14.4	15.9	450.1	3.8	3.5
Consultant Physician attendances	24.2	27	29.4	32.3	1,032.20	7.6	3.1
Operations (including anaesthetics)	40.2	50.3	36.8	39.1	2,207.50	9.2	1.8
Other Allied Health	2.2	2.6	3.1	3.8	282.6	0.9	1.3
Diagnostic Imaging	30.5	32.5	32.9	32.8	3,056.70	7.8	1.1
Other MBS services	22.8	27.4	13.9	15.8	1,839.50	3.7	0.9
General Practice and other non-referred attendances	46	49	47.6	48.5	6,588.00	11.4	0.7
Pathology	9.4	8.5	7.2	6.1	2,541.70	1.4	0.2
Total EMSN expenditure	**369**	**409.4**	**394.1**	**423.5**	**19,730.50**	**100**	**2.1**

*note that this table does not include benefits paid through other Commonwealth programmes, only those benefits which flow through the MBS.

7. The impact of the EMSN on patient out-of-pocket costs

Although the EMSN was intended to assist patients who have high out-of-pocket costs, it has had an inflationary impact in some areas.

In addition, while the Government pays 80 per cent of the increase in fees, the patient still pays the remaining 20 per cent. In some cases, the increase in fees has been so high that Departmental data indicates that patients face higher out-of-pocket costs than they would have if the safety net had not existed.

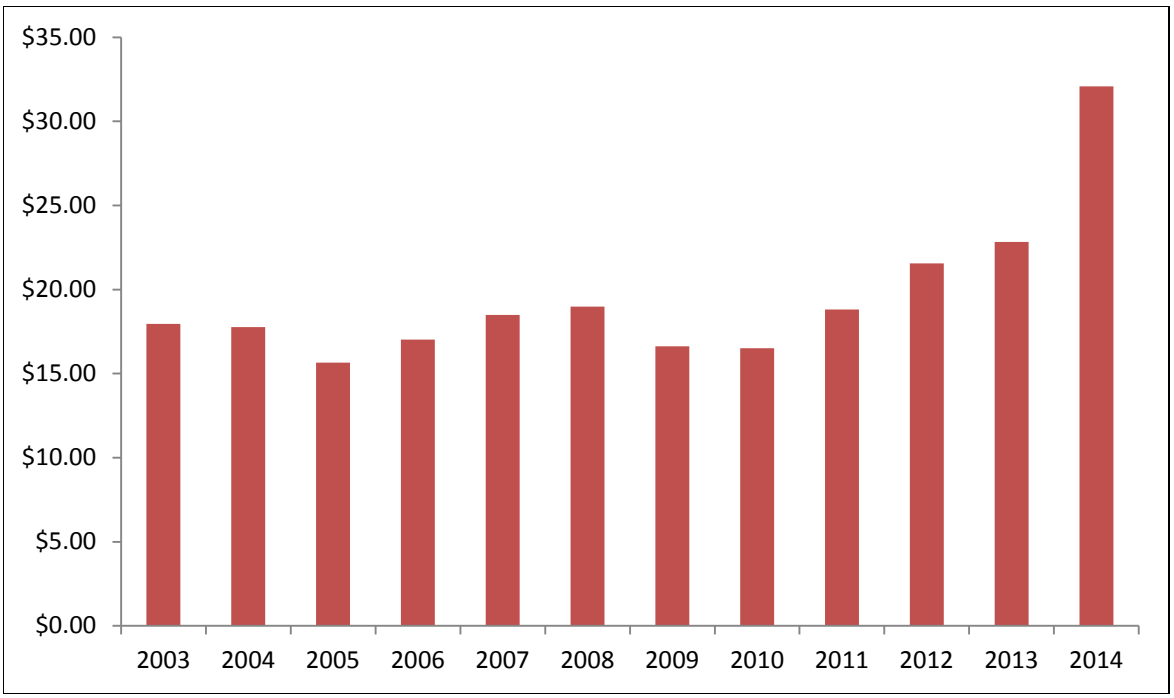
Caps were introduced on safety net benefits for selected items in 2010. These caps placed an upper limit on the Commonwealth contribution for the service. This has led to some moderation in the fees charged in some areas for these services.

Box 1 - Key Findings of the Extended Medicare Safety Net Review Report 2009

- Around 50 per cent of all EMSN benefits in 2007 were attributed to obstetrics and ART services.
- EMSN benefits have more than doubled for both these groups since 2004.
- The majority of EMSN benefits are distributed to the wealthier sections of the community.
- Nine per cent of families and less than 1 per cent of singles received EMSN benefits in 2007.
- That the EMSN is responsible for increases in fees charged overall, however, it has not caused an increase in the average fee charged for GP attendances, specialist consultations, pathology or diagnostic imaging services.
- In 2007, for every dollar spent on the EMSN, 43 cents went to providers as a result of higher fees charged and 57 cents went towards reducing patient out-of-pocket costs.
- For a group of items with high out-of-pocket costs, the amount going to providers was as high as 78 cents for some services, including some ART services, and procedures to treat varicose veins (item 32500) and vision impairments (items 42702 and 42740).
- Providers who generally charge high out-of-pocket costs per service are aware their patients are likely to qualify for EMSN benefits and may experience less market competition on fees.
- The structure of the EMSN has led to significant increases in provider fees for some services, as the EMSN provides benefits that increase with provider fees regardless of how high those fees are.
- The additional Government spending on EMSN benefits has not been matched by a reduction in patient out-of-pocket costs.

In areas without caps, such as radiation oncology, similar levels of fee inflation (and escalation in out-of-pocket costs) are now being observed. Radiation oncology is an area where recent fee increases, supported by the EMSN, mean that average out-of-pocket costs per service are higher now than before the EMSN was introduced.

Figure 4: Average out-of-pocket costs per out-of-hospital radiation oncology service 2003-2014



This figure above shows the change in average out-of-pocket costs for radiation oncology services since 2003, noting the significant increase between 2013 and 2014. The table below indicates that this is due to an increase in fees charged, as the number of services decreased between 2013 and 2014.

Table 11: Number of services and fees charged for private radiation oncology services funded by the MBS

	2013	2014
EMSN	$29,682,918.70	$44,164,054.43
Fees charged	$143,194,759.53	$155,135,954.99
Number of services	627,255	572,417

*****Please note the services represent out-of-hospital MBS services that were not bulk-billed.

8. The impact of EMSN benefit caps on fees charged

Box 2- Key finding of the Extended Medicare safety Net Review of Capping Arrangements Report 2011

- Capping put the EMSN on a more sustainable footing and contributed to restricting growth in expenditure and reducing the financial risk to Government resulting from increases in provider fees.
- The introduction of EMSN capping did not significantly impact the number of people receiving a benefit from the EMSN.
- EMSN capping did not (at that stage) appear to have changed the distribution of EMSN benefits by socioeconomic or regional area. However, the reduction in EMSN expenditure was relatively greater in wealthier areas and major cities, compared to lower socioeconomic and regional areas.
- Fees were found to moderate for Assisted Reproductive Technology services between 2009 and 2010 for patients in the sample.
- The number of hair transplantations funded under the EMSN decreased.
- Total number of cataract surgery services provided in hospital and out-of-hospital reduced by an average of 7.5 per cent, after increasing by 9.9 per cent between 2008 and 2009.
- Fewer varicose vein procedures were performed out-of-hospital between 2009 and 2010.
- This review concluded that the Government remained exposed to EMSN expenditure growth due to the volume of services used, the number of people/families who qualify for EMSN benefits, as well as fee increases for uncapped items.

EMSN benefit caps, which set the maximum amount of EMSN benefit that will be paid per service, were originally introduced in 2010. The 2011 review of the capping arrangements found caps reduced the fees charged at the higher deciles.

For example:

- the fees charged for varicose veins treatment by sclerotherapy (MBS item 32500) at the median and higher fell after a cap was introduced in 2010;
- the fees charged by obstetricians in the top 25 per cent of the fee distribution fell by $191 in 2010 as a result of the caps on obstetric items; and
- eye injections, for which the fees charged reduced from around $1,000 to $700 after the introduction of capping (Figures 5 and 6 below).

As an example of billing practice shifting around capped items, it is instructive to look at cataract surgery (shown visually at Figure 7 below). Caps were introduced for cataract surgery in 2010. The 2011 review found that the fees charged for MBS item 20142 – the initiation of management of anaesthesia for lens surgery (which was not capped) – increased by 400 per cent at the 90th percentile provider fee, indicating the possibility of provider fee sharing between ophthalmologists and anaesthetists to avoid the cap on cataract surgery**.**

Figure 5: Fee distribution for eye injection 2003-2014

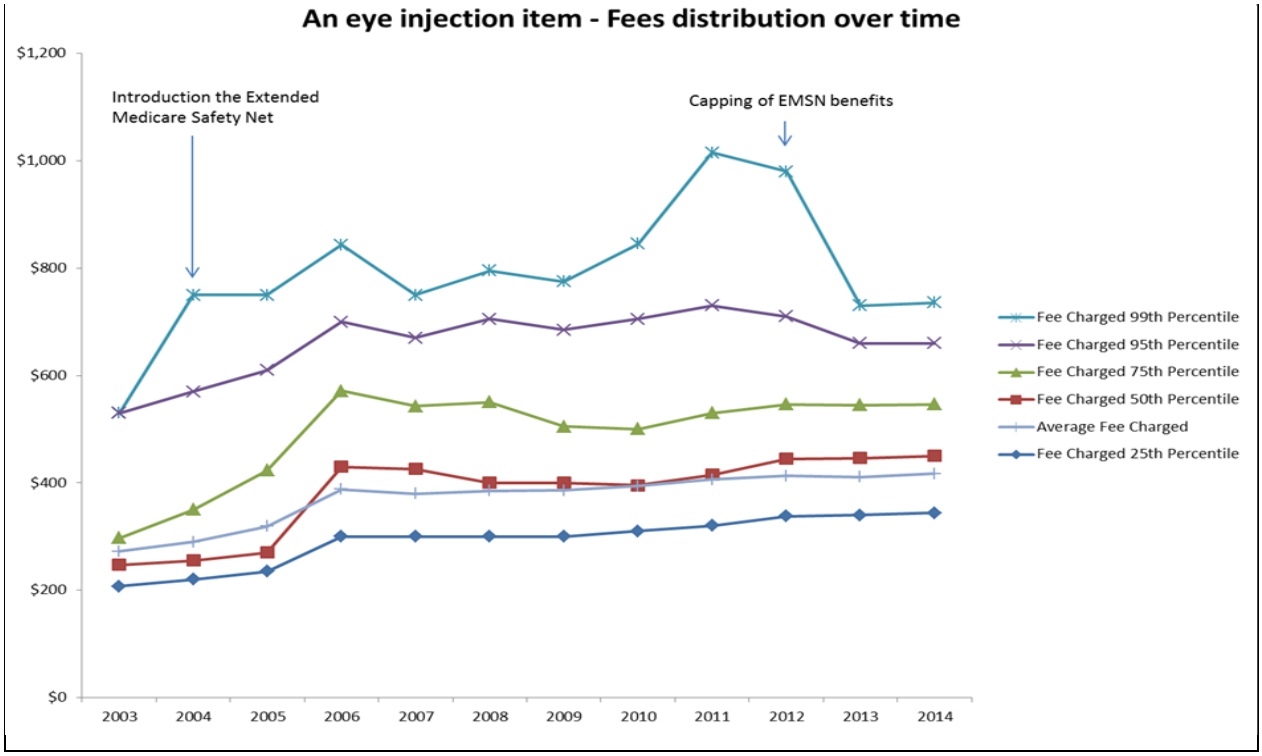


Figure 6: Changes in fee distribution after capping of benefits for eye injections

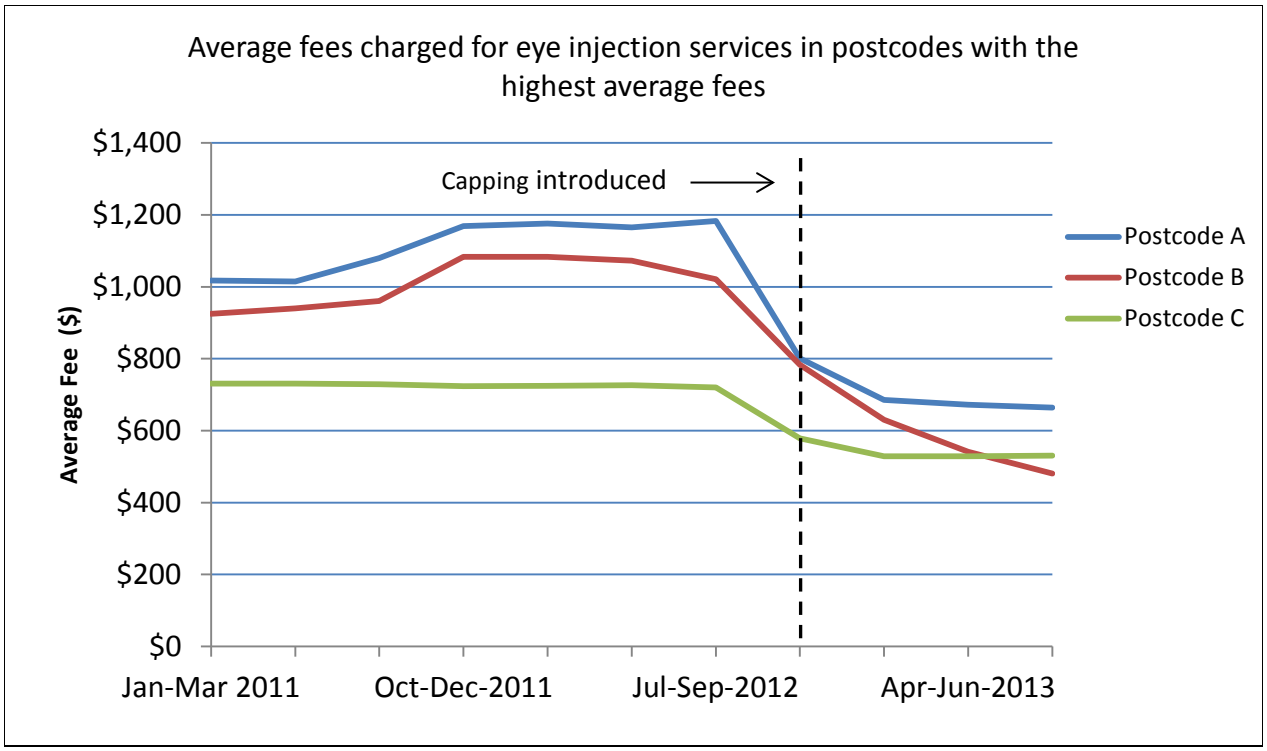
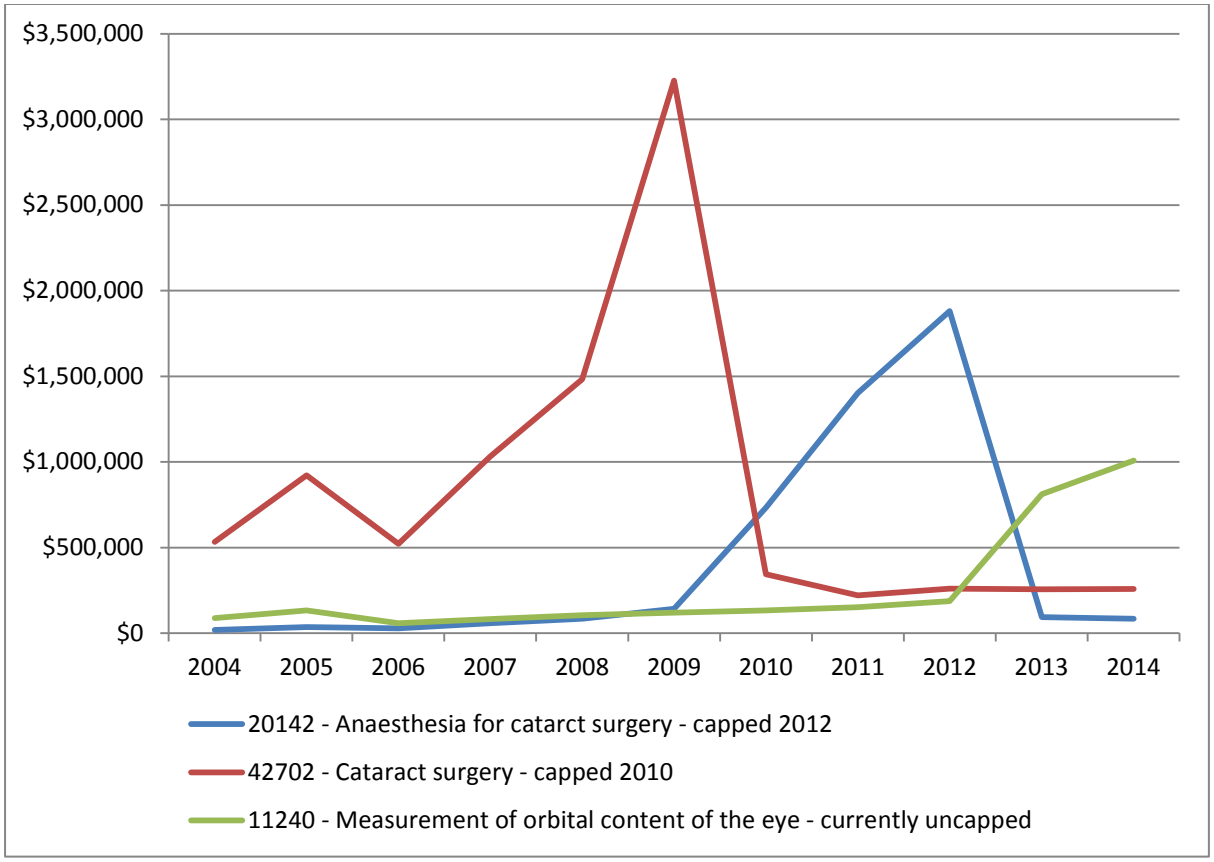


Figure 7: EMSN benefits paid for selected items associated with cataract surgery



When EMSN benefit caps were expanded in 2012, a cap was placed on the item for the initiation of anaesthesia in association with cataract surgery. Since then, some providers have shifted fees to other items, including to a routine diagnostic test. Although most doctors charge around $40 for the test, some patients have been billed over $1,000**.** While safety net benefit caps could be introduced for the diagnostic test item, currently there is the possibility that the high fee would move to another item. In some cases, doctors may be billing patients for additional items to avoid a cap, which is the type of practice that the new Medicare safety net would alleviate. That is, by capping benefits for all items, patients would be protected against this type of fee inflation in the future.

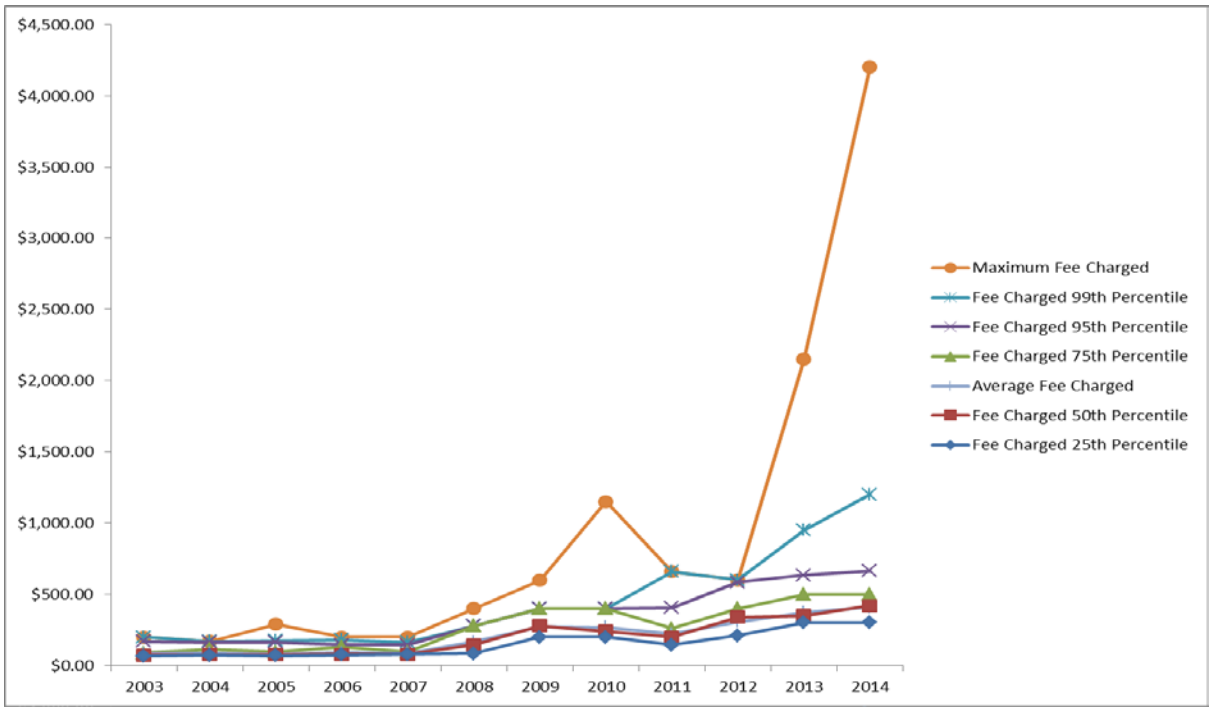
The opportunity to charge high fees (supported by the EMSN) may also present risks for patients, for example, by allowing doctors to provide services out-of-hospital which have not been assessed for safety and effectiveness. In some cases, the introduction of EMSN benefit caps has led to a shift to the more appropriate provision of a service in-hospital, rather than in a doctor's rooms. For example, Medicare data show:

- The average fee charged for vulvoplasty halved after the introduction of an EMSN benefit cap. The number of out-of-hospital services also reduced.
- EMSN benefit capping appears to have completely stopped the provision of liposuction for specific clinical indications (item 45585) out-of-hospital.
- The fees for upper eyelid reduction (item 45617) reduced by 40 per cent immediately after capping, and continued to reduce. The proportion of services provided out-of-hospital also reduced.

The need to introduce an accumulation cap

The EMSN has supported some practitioners to charge high fees for some services while the majority of practitioners charge much lower fees. For example, the figure below shows that the maximum fee charged for anaesthetic item 18270, an item with an MBS Fee of $88.25, increased to more than $4,200 in 2014. The average fee charged had increased to $408 (up from $83 in 2003 before the EMSN), an average annual growth of more than 18 per cent (adjusted for CPI inflation). It is anticipated that the changes to introduce an accumulation cap will moderate this type of fee setting arrangement.

Figure 8: Fee distribution for 18270 (injection of anaesthetic femoral nerve)



The 2009 review found that one of the main incentives for fee inflation was the ability for people to cross the threshold of the EMSN in a single high fee service. This is because when a practitioner knows a patient is likely to qualify for the EMSN, they can increase their fees with the knowledge the Government is paying the majority of the cost.

The Government cannot control what private providers charge and providers can charge a very high fee unrelated to the MBS Fee. For example, the maximum fee for brain stem audiometry (a form of hearing test) - an item with an MBS Fee of around $192 - increased to more than $3,995 in 2014. In this case the patient qualified for EMSN benefits in a single service and was rebated 80 per cent of all costs in excess of the relevant threshold. This practice has also become standard in the ART industry, where the average fee for the main item claimed for a stimulated IVF cycle (in 2014) is $7,000 and the MBS Fee is around $3,000. For this service charged at this fee, patients will always qualify for the EMSN and receive the maximum amount of safety net benefit available. In 2003 before the EMSN was introduced the average fee for the same item was around $2,000.

The accumulation cap will in many cases remove the incentive for providers to charge very high fees relative to the MBS Fee.

9. Impact of the new arrangements

The Department continues to consult with stakeholders and consumers regarding the proposed changes to the Medicare safety net.

The Department estimates an additional 53,000 people will receive a safety net benefit. The number of concession card holders is expected to increase by 80,500. The number of non-concessional card holders is expected to decrease by 27,500 however there will be a net increase in non-concessional single people.

Much attention has been directed toward the specific impact of these changes on radiation oncology, psychiatry and ART services. Further specific analysis into these areas is outlined below and data on the top 20 statistical areas receiving benefits in these categories are at Attachment B.

Radiation oncology

Based on current charging behaviour, it is estimated that an additional 1,000 people will receive safety net benefits under the new arrangements due to lower thresholds. Eight hundred of these people will be concession card holders.[6]

In 2014, around 70 per cent of radiation oncology services were bulk-billed and more than 80 per cent of all services charged at the MBS Fee or less. This means a large proportion of patients experience no or low out-of-pocket costs for their treatment. The new Medicare safety net is not expected to lead to any reduction in patient care and a significant proportion of families and individuals who incur out-of-pocket costs for radiation oncology will qualify for the safety net sooner because of the reduced thresholds.

The costs that patients incur for private radiation oncology will depend on the fees charged by private providers. About 40 per cent of all radiation oncology services are provided by private providers and around 70 per cent of those services are provided by a single radiation oncology company. Data show that since 2004, average fees for private radiation oncology patients grew steadily at around 5.2 per cent per annum to 2013. From the fourth quarter of 2013 to the fourth quarter of 2014 the average fee for non-bulk-billed services increased 22.9 per cent.

There have been suggestions out-of-pocket costs may triple under the new Medicare safety net, but in order for this to happen, private providers would have to charge around 2.5 times the MBS Fee for a course of treatment. The Department estimates that a 'standard' course of treatment, defined by industry as 20 treatments of 3-field radiotherapy, will, if every service is charged at the 2014 average fee, have a charge of $11,433. Under the current arrangements, this treatment would be rebated at $8,807, leaving an out-of-pocket cost of $2,626. Under the new arrangements, this course of treatment would be rebated at $8,784, leaving an out-of-pocket cost of $2,649.

[6] Figures for individuals are based on the person meeting the safety net receiving only radiation oncology services, but it is likely he/she would reach the safety net through a combination of service types.

Claims have been made that higher fees for radiation oncology are partly due to 'new' technology such as Intensity-Modulated Radiation Therapy (IMRT), Image-Guided Radiation Therapy (IGRT) and stereotactic radiosurgery (SRS). MSAC recently reviewed IMRT and IGRT and the Department is currently working with radiation oncology providers and the Royal Australian and New Zealand College of Radiologists on implementing the MSAC recommendations. MSAC has considered increased funding for SRS on four occasions (for Gamma Knife and CyberKnife machines). MSAC indicated that these applications lacked high quality evidence of superior patient outcomes in comparison to conventional treatment to warrant an increase in public funding for these machines.

Most private radiation oncology facilities are in major capital cities where patients have a choice of providers. As referred to above, currently, about 40 per cent of services are provided by private providers. This percentage has remained stable or risen slightly in the last five years. In relation to waiting times, on 11 November 2015, the Australian Institute of Health and Welfare released *Radiotherapy in Australia: Report on a pilot data collection 2013-14*, which indicated that patients requiring urgent radiotherapy (2 percent of cases) are usually treated within a day, and patients with non-urgent conditions usually wait less than two weeks for treatment.

The Commonwealth provides significant funding for radiation oncology services which continues to grow. Private radiation oncology services are funded through MBS rebates, EMSN benefits, patient co-payments, and direct capital funding through the Radiation Oncology Health Program Grants (ROHPG) scheme.

Table 12: Total funding for radiation oncology services 2004-5 to 2014-15

	2004-05	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
	$m	$m	$m	$m	$m	$m	$m	$m	$m	$m	$m
ROHPG	32.2	30.1	42.1	51.4	62.2	62.5	64.1	62.7	61.2	62.1	68.5
MBS Benefits	89.6	103.1	117.9	137.0	170.0	197.1	205.0	225.3	248.5	261.0	286.8
Safety Net	11.9	13.2	14.1	16.3	20.1	24.0	26.5	30.3	33.9	39.1	55.9
Total	133.7	146.4	174.2	204.7	252.4	283.6	295.6	318.3	343.5	362.2	411.2

Psychiatry

It is estimated that if current billing practices remain unchanged, 2,300 more people will receive safety net benefits for psychiatry services. Under current billing practices, at least 3,400 extra people who have a concession card will receive safety net benefits and the number of non-concessional people receiving safety net benefits will reduce by approximately 1,000.

A small number of patients may experience an increase in out-of-pocket expenses, depending on the fees they are charged by their doctor. Data show that EMSN benefits for psychiatry services are largely distributed (52.5 per cent) to the more affluent areas of inner Melbourne, Sydney and Brisbane.

The Department estimates that in 2016, a concessional person not receiving any other services would take five psychiatric services to reach the new Medicare safety net threshold, if they were charged the 2014 average fee. A non-concessional person in 2016 also charged the 2014 average fee for their services would take 10 services.

Table 13: Concessional person reaches $400 threshold in 5 services

Item	Description	Number of services:	Fee charged per service[1]	Schedule Fee per service	Total (combined) accumulation towards the threshold[2]
23	GP attendance (referral to psychiatrist)	1	$67.80	$37.05	$18.53
296	Initial psychiatric assessment, greater than 45 minutes	1	$347.35	$260.30	$126.02
306	Psychiatric consultation, 45-75 minutes	3	$264.80	$183.65	$325.95

[1]Average fee charged in 2014 for patient-billed, out-of-hospital service
[2]Accumulation towards the threshold for each service is calculated as
[fee charged for the service – the out-of-hospital rebate], with a maximum value of
[150% of the MBS Fee – the out-of-hospital rebate]. Further information is available at www.mbsonline.gov.au

Table 14: Non-concessional person reaches $1,000 threshold in 10 services

Item	Description	Number of services:	Fee charged[1]	Schedule Fee	Total accumulation towards the threshold[2]
23	GP attendance (referral to psychiatrist)	1	$67.80	$37.05	$18.53
296	Initial psychiatric assessment, greater than 45 minutes	1	$347.35	$260.30	$126.02
306	Psychiatric consultation, 45-75 minutes	8	$264.80	$183.65	$869.20

[1]Average fee charged in 2014 for patient-billed, out-of-hospital service
[2]Accumulation towards the threshold for each service is calculated as
[fee charged for the service – the out-of-hospital rebate], with a maximum value of
[150% of the MBS Fee – the out-of-hospital rebate]. Further information is available at www.mbsonline.gov.au

Some of the concern from the sector relates to services provided under MBS item 316 (45 – 75 minute consultation where a patient has had more than 50 consultations in a calendar year and does not have a severe condition). Based on current services the Department estimates that approximately 140 of the 560 patients who use this service may be affected if practitioners do not change their billing practices. Item 319 provides another avenue for patients who require long term frequent psychiatric visits, should patients meet the relevant clinical criteria. Current data show that around 1,600 patients access this service under MBS item 319, and the majority will not be affected by the changes to the Medicare safety net.

For allied health services, which include psychology, at least 13,500 extra people who have a concession card will receive safety net benefits, on the basis of current charging behaviour and usage patterns. Data show that the majority of the four highest claimed Medicare items for psychology are charged at less than 150 per cent of the MBS Fee.

Artificial Reproductive Technology (ART)

The Government's arrangements for Medicare funding of ART services are some of the most generous in the world, providing for unlimited treatment cycles, a rebate of around $5,300 per stimulated cycle, and no upper age restrictions on eligibility. Around 90 per cent of patients currently accessing safety net benefits for ART services are non-concessional and located in the higher socioeconomic inner areas of Sydney, Melbourne and Brisbane.

ART services are already subject to benefit caps. As a result, if charging behaviour remains the same, it is estimated that the vast majority of people will not be financially impacted for their first IVF cycle. MBS data show an initial IVF cycle on average costs $8,100. Under the current arrangements, a patient having an initial stimulated IVF cycle would receive total Medicare benefits (including safety net benefits) of around $5,280. Under the new Medicare safety net, a patient would receive total Medicare benefits of $5,270 (this assumes a non-concessional patient who has had no previous services).

Departmental data show the 2nd stimulated IVF cycle within the same year costs an average of $8,100. For two cycles a patient would be charged around $16,220 and receive $11,135 in Medicare rebates (including safety net benefits). This would leave them with a total of $5,085 in out-of-pocket expenses for 2 stimulated IVF cycles. Under the new Medicare safety net, a patient would receive $10,282 in Medicare rebates, for a total of $5,937 in out-of-pocket expenses; a reduction in existing safety-net benefits of around $850.[7]

There is no evidence to confirm the claims about the potential of the safety net amendments to lead to more multiple births. In Australia it is a requirement for accredited ART practices to have a target for multiple birth rates at less than 10 per cent. It is expected that doctors will continue to consider patient safety and ethics in providing these types of services. The ART market is also competitive, with a number of low cost ART practices operating in Australia, some which offer services with no out-of-pocket costs for their patients or with fees of less than $1,000 for a stimulated cycle. These practices will be unaffected by the changes to the Medicare safety net arrangements.

General Practice

Safety net benefits currently only account for 0.7 per cent of total benefits paid for GP services, as fees for these services are generally low and a high proportion of people are bulk-billed. The bulk-billing rate for concession card holders is 91.3 per cent, which means that these people do not have out-of-pocket costs for these services and are therefore unlikely to be affected by these changes.

The majority of people receiving safety net benefits for a GP service have qualified for benefits from specialist services that year. In relation to qualifying for the EMSN via GP visits only, a concessional person, charged the 2014 average fee of $67.80, would qualify on their 21st service.[8] Under the new arrangements the same person would qualify on their 22nd service.

[7] Departmental estimates based on average fees charged in 2014.
[8] The average fee is derived from 2014 MBS data on out-of-hospital services that are patient billed.

10. Conclusion

The current safety net arrangements (comprising the OMSN, the EMSN and the GPG rule) are complex, overlapping, inflationary and regressive. It is hard for practitioners and patients to understand them. The EMSN which was introduced in 2004 was intended to "protect all Australians from high out-of-pocket expenses"[9]. As indicated in the 2009 review:

> "*The Medicare program caps the amount of benefits per service. The EMSN, on the other hand, provides benefits that increase with provider fees, regardless of how high those fees may be. This feature has resulted in significant increases in provider fees for some services and has meant that patients do not receive the full benefit of the EMSN*"[10].

Over time the out-of-pocket costs for a large number of medical services have increased by significant amounts. In some areas, such as ART, evaluation reports indicate that this is likely to be as a direct result of the introduction of the EMSN. The data clearly show that benefits are disproportionately going to the more socioeconomic advantaged areas of society. The data also confirm that the introduction of capping has an impact on billing behaviour by providers, putting downward pressure on fees charged.

In addition, the introduction of the accumulation cap (towards the threshold) will end what the 2009 review found was one of the main incentives for fee inflation; the ability for people to cross the threshold of the EMSN in a single high fee service. This means patients currently receiving services for which fees are charged in excess of 150 per cent of the MBS Fee for this purpose will see a change.

Importantly, under the new safety net arrangements, benefits are redistributed toward concessional patients, with around 80,500 additional concessional people to become eligible. In addition, non-concessional singles will be better off. This is an important cohort which is often only at the periphery of the policy discussion. The improved flexibility around family eligibility and changes in composition of families brings the legislation into greater alignment with contemporary views of blended families. In addition, the changes include administrative design benefits, reducing red tape on people interacting with the Department of Human Services.

The *Health Insurance Amendment (Safety Net) Bill 2015* has been carefully designed to simplify the current arrangements, be more progressive and put Medicare on a sustainable path. The implementation of a new Medicare safety net will generate savings of more than $266.7 million. This Bill will help more patients access safety net benefits; will improve access for singles, students, children in multiple families and elderly couples; and will provide a mechanism by which Government can responsibly manage expenditure under this programme and ensure its ongoing sustainability for all Australians.

Finally, while it is acknowledged there is much reform underway in other parts of the health system, particularly in relation to fee structure and the contemporary delivery of services, it is considered that implementation of the Medicare safety net changes now will provide transparency and certainty, which can then be taken into consideration by longer-term work programmes of the MBS Review Taskforce and the Primary Health Care Advisory Group.

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[9] Hansard. House of Representatives. 4 December 2003. Second Reading for the *Health Legislation Amendment (Medicare) Bill 2004.*

[10] Centre for Health Economic Research and Evaluation, (2009) *Extended Medicare Safety Net Review Report 2009*, Canberra, p. vii.

Attachment A: Examples of Medicare Safety Net Calculations

How the caps are calculated under the new Medicare safety net

DHS will automatically calculate out-of-pocket costs that accumulate to the threshold and Medicare safety net benefits. The following example shows how caps will be calculated for an initial specialist consultation (MBS item 104) which has an MBS fee of $85.55 and an out-of hospital Medicare benefit (rebate) of $72.75.

MBS Fee	MBS item 104	$85.55
MBS Rebate (out-of-hospital)	85% of MBS Fee	85% of $85.55 = $72.75

1. Accumulation cap

The safety net accumulation cap percentage for this item (item 104) is 150%. This means that the maximum which can accumulate towards the safety net threshold is 150% of the MBS Fee of $85.55 less the MBS rebate of $72.25.

Maximum amount which can accumulate to the threshold (**Accumulation Cap**)
= 150% of the MBS Fee of $85.55 minus the rebate of $72.75
= $128.33 (with rounding up to the nearest cent) minus $72.75
= $55.58

MBS Fee	$85.55	
MBS Rebate (out-of-hospital)	85% of MBS Fee	85% of $85.55 = $72.75
Accumulation cap	150% MBS Fee – MBS rebate	(150% of $85.55) - $72.75 = $55.58

2. Benefit cap

The total benefit cap percentage for this item (item 104) is 150%. The maximum safety net benefit payable is 150% of the MBS Fee of $85.55 less the MBS rebate of $72.75.

Maximum safety net benefit (**Safety Net Benefit Cap**)
= 150% of the MBS Fee of $85.55 minus the rebate of $72.75
=$128.35 (with rounding up to nearest 5c) minus $72.75
=**$55.60**

MBS Fee	$85.55	
MBS Rebate (out-of-hospital)	85% of MBS Fee	85% of $85.55 = $72.75
Benefit cap	150% MBS Fee – MBS rebate	(150% of $85.55) - $72.75 = $55.60

Examples of qualifying for safety net benefits

Example 1:

A patient is charged $120 for a specialist consultation. The rebate is $72.75, leaving an out-of-pocket cost of $47.25. As this out-of-pocket amount is below the maximum amount allowed to be counted towards the threshold for this item, $47.25 is counted towards the patient's threshold.

Amount accumulated to the safety net threshold

New Medicare safety net	**EMSN**
$47.25	$47.25

Fee charged		$120
MBS Fee	MBS item 104	$85.55
MBS Rebate	85% of MBS Fee	85% of $85.55 = $72.75
Accumulation Amount	**Lower of:** 1. out-of-pockets (fee charged less MBS rebate) **OR** 2. accumulation cap (150% of MBS Fee – MBS rebate)	**Lower of:** 1. $120 -$72.75 = $47.25 **OR** 2.(150% of $85.55)- $72.75 = $55.58* 1<2 = $47.25 accumulates

Example 2:

A patient is charged $150 for the consultation. The rebate is $72.75, leaving an out-of-pocket cost of $77.25. As this out-of-pocket is more than the maximum amount allowed to be counted towards the threshold for this item, only $55.58 is counted to the threshold.

Amount accumulated to the safety net threshold

New Medicare safety net	**EMSN**
$55.58	$77.25

Fee charged		$150
MBS Fee	MBS item 104	$85.55
MBS Rebate	85% of MBS Fee	85% of $85.55 = $72.75
Accumulation Amount	**Lower of:** 1. out-of-pockets (fee charged less MBS rebate) **OR** 2. accumulation cap (150% of MBS Fee – MBS rebate)	**Lower of:** 1. $150 -$72.75 = $77.25 **OR** 2.(150% of $85.55) -$72.75 = $55.58* 2<1 = $55.58 accumulates

*Accumulation caps are rounded up to the nearest cent. Benefit caps are rounded up to the nearest 5 cents.

Examples of calculating benefits once the threshold is reached

Example 1:
A patient is charged $120 for a specialist consultation. The rebate is $72.75, leaving an out-of-pocket cost of $47.25. Medicare safety net benefits are calculated as 80% of the out-of-pocket costs, which is $37.80 (80% of $47.25). This is less than the maximum safety net benefit of $55.60. Therefore the patient receives a safety net benefit of $37.80. The patient's net out-of-pocket cost after the total Medicare benefits are paid is $9.45 ($120 less $110.55 in total benefits).

Safety Net Benefit Amount

New Medicare safety net	**EMSN***
$37.80	$37.80

Fee charged		$120
MBS Fee	MBS item 104	$85.55
MBS Rebate	85% of MBS Fee	85% of $85.55 = $72.75
Safety net benefit	**Lower of:** 1. 80 % of out-of-pockets 80% (fee charged less MBS rebate) **OR** 2. benefit cap (150% of MBS Fee) – MBS rebate	**Lower of:** 1. 80% of ($120 -$72.75)= $37.80 **OR** 2.(150% of $85.55)- $72.75 = $55.60 (rounded up to nearest 5c) 1<2 = $37.80 safety net benefit
Total Benefit	**Lower of:** 1. Safety net benefit + MBS Rebate **OR** 2. 150% of MBS Fee	**Lower of:** 1. $37.80+$72.75 = $110.55 **OR** 2. 150% of $85.55 = $128.35 (rounded up to nearest 5c) 1<2 => $110.55 total benefits paid

Example 2:
A patient is charged $150 for a specialist consultation. The rebate is $72.75, leaving an out-of-pocket cost of $77.25. Medicare safety net benefits are calculated as 80% of the out-of-pocket costs, which in this case is $61.80 (80% of $77.25). However, the maximum safety net benefit is $55.60. Therefore the patient receives $55.60 in safety net benefits. The patient's net out-of-pocket cost after the total Medicare benefits are paid is $21.65 ($150 less $128.35 in total benefits).

Safety Net Benefit Amount

New Medicare safety net	**EMSN***
$55.60	$61.80

Fee charged		$150
MBS Fee	MBS item 104	$85.55
MBS Rebate	85% of MBS Fee	85% of $85.55 = $72.75
Safety net benefit	**Lower of:** 1. 80 % of out-of-pockets 80% (fee charged less MBS rebate) **OR** 2. benefit cap (150% of MBS Fee – MBS rebate)	**Lower of:** 1. 80% of ($150 -$72.75) = $61.80 **OR** 2. (150% of $85.55)- $72.75 = $55.60 (rounded up to nearest 5cents) 1>2 = $55.60 safety net benefit
Total Benefit	**Lower of:** 1. Safety net benefit + MBS Rebate **OR** 2. 150% of MBS Fee	**Lower of:** 1. $55.60+$72.75 = $128.35 **OR** 2. 150% of $85.55 = $128.35 (rounded to the nearest 5c) 1=2 => $128.35 total benefits paid

* Under the existing EMSN, the safety net benefit is calculated as 80% of all out-of-pocket costs. However, for some MBS items (including obstetrics, Assisted Reproductive Technology, consultation items and selected other items) safety net benefits are capped. For MBS item 104 the EMSN cap on benefits is $256.65, which does not have any impact on the examples provided.

Attachment B: EMSN benefits for the top 20 statistical areas

Table 1: The top 20 Statistical Areas (level 4) receiving EMSN benefits for psychiatry services in 2014[11]

Location (Statistical Area 4)	EMSN Benefit	EMSN proportion of Medicare revenue (total out-of-hospital benefits)
Melbourne - Inner	$2,776,970	15.20%
Sydney - North Sydney and Hornsby	$2,749,305	22.60%
Sydney - Eastern Suburbs	$2,216,800	24.07%
Sydney - City and Inner South	$1,888,725	20.68%
Melbourne - Inner South	$1,815,356	15.88%
Melbourne - Inner East	$1,603,198	16.25%
Sydney - Inner West	$1,533,516	21.05%
Brisbane Inner City	$1,008,414	14.31%
Sydney - Northern Beaches	$929,132	20.43%
Melbourne - Outer East	$706,791	10.26%
Brisbane - South	$698,477	11.37%
Melbourne - South East	$690,816	8.19%
Brisbane - West	$686,126	15.38%
Sydney - Inner South West	$640,786	12.03%
Sydney - Ryde	$615,209	17.58%
Australian Capital Territory	$595,886	21.71%
Melbourne - North East	$580,470	7.19%
Sydney - Sutherland	$574,094	20.10%
Perth - North West	$559,074	14.35%
Melbourne - West	$530,741	7.13%

[11] An SA4 region is a geographical areas defined by the ABS with a population of between 100,000 and 500,000 people. There are 88 SA4 regions that cover the whole of Australia without gaps or overlaps. In regional areas, SA4s tend to have populations closer to the minimum (100,000 - 300,000). In metropolitan areas, the SA4s tend to have larger populations (300,000 - 500,000).

Table 2: The top 20 Statistical Areas (level 4) receiving EMSN benefits for Assisted Reproductive Technology Services in 2014

Location (Statistical Area 4)	EMSN Benefit	EMSN proportion of Medicare revenue (total out-of-hospital benefits)
Melbourne - Inner	$5,168,455	38.70%
Melbourne - West	$3,291,018	37.59%
Melbourne - Inner South	$2,619,573	38.34%
Melbourne - South East	$2,581,175	37.78%
Sydney - North Sydney and Hornsby	$2,551,095	36.32%
Sydney - Eastern Suburbs	$2,523,237	36.04%
Melbourne - North East	$2,415,967	37.86%
Sydney - Inner South West	$2,180,577	32.05%
Sydney - City and Inner South	$2,118,716	35.37%
Perth - North West	$2,093,835	35.99%
Melbourne - Outer East	$2,075,426	37.93%
Gold Coast	$1,902,094	36.01%
Melbourne - Inner East	$1,897,410	38.70%
Sydney - Inner West	$1,845,609	35.32%
Brisbane Inner City	$1,831,176	35.92%
Brisbane - South	$1,665,408	35.60%
Australian Capital Territory	$1,644,417	36.12%
Melbourne - North West	$1,548,847	37.58%
Sydney - Northern Beaches	$1,458,634	35.69%
Perth - South East	$1,366,607	35.55%

Table 3: The top 20 Statistical Areas (level 4) receiving EMSN benefits for Radiation Oncology Services in 2014

Location (Statistical Area 4)	**EMSN Benefit**	**EMSN proportion of Medicare revenue (total out-of-hospital benefits)**
Gold Coast	$3,091,903	27.67%
Sydney - North Sydney and Hornsby	$2,135,282	27.85%
Melbourne - Outer East	$1,932,334	21.78%
Perth - North West	$1,697,540	21.48%
Adelaide - Central and Hills	$1,538,457	28.83%
Mornington Peninsula	$1,451,238	23.79%
Adelaide - South	$1,330,116	19.61%
Hume	$1,271,433	31.03%
Murray	$1,039,872	31.00%
Brisbane - North	$1,032,814	30.16%
Perth - South East	$1,030,816	18.13%
Brisbane - West	$972,817	33.33%
Melbourne - Inner	$970,095	14.97%
Adelaide - North	$954,754	16.76%
Adelaide - West	$953,903	23.57%
Sydney - Northern Beaches	$950,636	20.42%
Richmond - Tweed	$909,999	18.67%
Moreton Bay - South	$865,601	31.68%
Melbourne - West	$849,827	12.05%
Brisbane Inner City	$847,640	26.65%