Chapter 1
Introduction

Referral

1.1 On 12 November 2015, the Senate referred the provisions of the Health Insurance Amendment (Safety Net) Bill 2015 (Bill) to the Senate Community Affairs Legislation Committee (committee) for inquiry and report by 23 November 2015.[1]

Objective of the Bill

1.2 The Bill seeks to amend the *Health Insurance Act 1973* to introduce a new Medicare Safety Net, to replace the Original Medicare Safety Net (OMSN), Extended Medicare Safety Net (EMSN) and the Greatest Permissible Gap.[2]

1.3 In the second reading speech, the Hon Sussan Ley MP, Minister for Health (Minister), said that the Bill:

> …will ensure that a strong safety net continues to protect all Australians from high out-of-pocket costs for medical services provided out of hospital. It will also address many of the known equity and complexity issues of the current arrangements.[3]

1.4 The Minister identified four issues that the Bill aims to address:

> The current safety nets are complicated and confusing…they work in different ways and have different thresholds. They interact with each other and can sometimes all be applicable to the same medical service. They are unnecessarily complex and difficult to understand.
>
> The current arrangements are also inconsistent. There is a limit on safety net benefits that will be paid for some but not all out-of-hospital services. Some of these limits are fixed dollar amounts, while others are based on a percentage of the Medicare fee. This inconsistency in arrangements can be very confusing for patients and medical practitioners.
>
> While most doctors charge reasonable fees for their services, some doctors and service providers have used the Extended Medicare Safety Net to underwrite excessive fees. This has led to increased patient out-of-pocket costs in some areas...
>
> The current arrangements may also support less safe medical practice, such as providing complicated surgical services out of hospital to take

1 *Journals of the Senate*, No. 126–12 November 2015, pp 3373–3374.

2 Explanatory Memorandum (EM), p. 1.

3 *House of Representatives Hansard*, 21 October 2015, p. 5.

> advantage of the unlimited rebate available under the Extended Medicare Safety Net.[4]

1.5 The Minister stated that previous changes to the EMSN had attempted unsuccessfully to address these issues. The changes increased the program's complexity and left two particular issues unresolved: 'excessive fee inflation can still occur to services that are uncapped' and 'some people reach their threshold almost immediately due to the unlimited amount of out-of-pocket costs that count towards the threshold', desensitising patients to further fees and allowing for fee inflation.[5]

1.6 The Minister concluded:

> The time is right to replace the complex, inefficient Medicare safety net arrangements with a new Medicare safety net. The new Medicare safety net will strengthen the system for patients into the future while contributing to a more sustainable Medicare system. Its design has been informed by the findings of two independent reviews; ongoing consultation with the medical profession since the introduction of the Extended Medicare Safety Net in 2004; and concerns raised by patients.[6]

Background to the Bill

1.7 At present, Medicare safety net arrangements include the OMSN, the EMSN and the Greatest Permissible Gap. Of these arrangements, the EMSN accounts for the majority of expenditure[7] and has been independently reviewed twice in the past six years, followed by the Government's announcement of the current measure in the 2014–15 Budget.

Safety net arrangements affected by the Bill

1.8 The OMSN was introduced in its current form in 1991. It increases the general rebate for out-of-hospital Medicare services to 100 per cent of the Medicare

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4 *House of Representatives Hansard*, 21 October 2015, p. 5. Out-of-hospital services include general practitioner (GP) and specialist attendances, and services provided in private clinics and private emergency departments.

5 *House of Representatives Hansard*, 21 October 2015, p. 6. Also see: Department of Health (Department), *Submission 18*, p. 9.

6 *House of Representatives Hansard*, 21 October 2015, p. 6.

7 The Hon Sussan Ley MP, Minister for Health (Minister), *House of Representatives Hansard*, 21 October 2015, p. 5; Department, *Submission 18*, p. 6.

Also see: Centre for Health Economics Research and Evaluation (CHERE), *Extended Medicare Safety Net, Review of Capping Arrangements Report 2011*, 2011, pp 21–22, http://www.health.gov.au/internet/main/publishing.nsf/Content/2011_Review_Extended_Medicare_Safety_Net/$File/Final%20Report%20-%20Review%20of%20EMSN%20benefit%20capping%20June%202011.pdf (accessed 20 November 2015). This report noted that Extended Medicare Safety Net (EMSN) expenditure grew from $231.2 million to $538.6 million (an increase of 133 per cent in 2011 real terms) for the period 2004–2009, compared with Original Medicare Safety Net (OMSN) expenditure which grew from $11.1 million to $13.2 million (an increase of 40 per cent in 2011real terms), for the same period (Table 3.1).

Benefits Schedule (MBS) fee once an annual threshold of gap costs has been met.[8] In 2015, the annual threshold is $440.80.[9]

1.9 The EMSN was introduced in 2004. It provides an additional rebate (80 per cent of out-of-pocket costs) for families and singles whose out-of-pocket costs for out-of-hospital Medicare services reach an annual threshold. In 2015, the annual threshold is $2,000 for families and singles, and $638.40 for Commonwealth concession cardholders and people who are eligible for Family Tax Benefit Part A (FTB(A)).[10]

1.10 The Greatest Permissible Gap was introduced in 1984. It increases the rebate for high cost out-of-hospital Medicare services, so that the difference between the rebate and the MBS fee is no more than $79.50.[11]

2009 and 2011 independent reviews

1.11 In 2009 and 2011, the EMSN was independently reviewed by the Centre for Health Economics Research and Evaluation (CHERE).

Extended Medicare Safety Net, Review Report 2009 (2009 review)

1.12 The 2009 review analysed the operation of the EMSN, the extent to which the EMSN had achieved its stated purpose, and any changes to Medicare billing and peoples' access to services which were directly attributable to the introduction of the EMSN.[12]

1.13 CHERE reported that despite its objective—to provide financial relief to families and singles who incur high out-of-pocket costs for out-of-hospital medical services, thereby making healthcare more affordable—the EMSN appeared not to have achieved its objective:

> The EMSN appears to have made services more affordable for some (people using assisted reproductive services, some patients with complex health conditions such as cancer), but has had little impact for those in more remote areas or in lower socioeconomic groups. Despite the lower threshold for low and middle income households, the EMSN appears to be a relatively ineffective way to direct higher benefits to those households.
>
> A concern is that most EMSN benefits have flowed to services that are more often used by wealthier sections of the community. The implication of this is that the EMSN has increased the affordability of high-cost services for these groups, but has had relatively little impact on the affordability of medical services for other sections of the Australian population. In this

8 Gap costs are the difference between the rebate and the Medicare Benefits Schedule (MBS) fee.

9 EM, p. 2.

10 EM, p. 1.

11 EM, p. 2.

12 CHERE, *Extended Medicare Safety Net, Review Report 2009*, 2009, p. v, http://www.health.gov.au/internet/main/publishing.nsf/content/review_%20extended_medicare_safety_net/$file/extendedmedicaresafetynetreview.pdf (accessed 20 November 2015).

> sense, the EMSN is a poorly targeted policy because it has not addressed one of the main barriers to access that many patients on low incomes face.[13]

1.14 CHERE concluded also that the introduction of the EMSN had fundamentally affected the fees charged for out-of-hospital Medicare services:

> The EMSN…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.
>
> The impact of the EMSN on fees is most pronounced for Medicare items that are usually associated with high out-of-pocket costs per service. We believe that providers know, if they bill these items, their patients are likely to qualify for EMSN benefits. Under these circumstances, providers feel fewer competitive constraints on their fees.[14]

1.15 In response to these findings, the Government introduced caps on the amount of EMSN benefits paid for about 570 MBS items—such as obstetric services, pregnancy related ultrasounds, assisted reproductive technology (ART) services, cataract surgery, hair transplantation, a varicose veins procedure and midwifery services.[15]

Extended Medicare Safety Net, Review of Capping Arrangements Report 2011 (2011 review)

1.16 The 2011 review evaluated:

- the operation of capping EMSN benefits;
- the extent to which EMSN caps had made the program more sustainable into the future; and
- changes to fees charged, services provided and patient out-of-pocket costs for the capped items since the introduction of EMSN caps.[16]

1.17 Although it was too early to gauge the full effect of EMSN caps, CHERE reported that the capping arrangements had clearly reduced program expenditure. CHERE warned however that there remained the possibility of increased program expenditure:

> For capped items, the introduction of EMSN caps has removed the government's financial exposure to provider fee rises. However, the government remains exposed to EMSN expenditure growth due to the

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13 CHERE, *Extended Medicare Safety Net, Review Report 2009*, 2009, p. vii.

14 CHERE, *Extended Medicare Safety Net, Review Report 2009*, 2009, p. vii.

15 CHERE, *Extended Medicare Safety Net, Review of Capping Arrangements Report 2011*, 2011, p. 3; Department, *Submission 18*, p. 8. The capping arrangements were accompanied by increases in the Medicare rebate for a number of obstetrics services and a restructure of MBS items for assisted reproductive technology services.

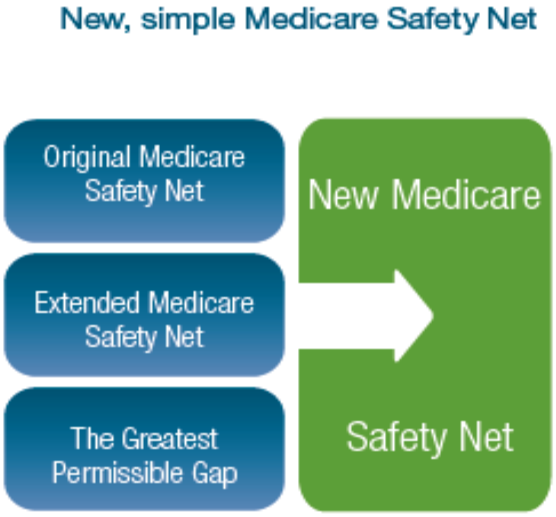
16 CHERE, *Extended Medicare Safety Net, Review of Capping Arrangements Report 2011*, 2011, p. 3.

volume of services used, the number of people/families who qualify for EMSN benefits, as well as fee increases for uncapped items.[17]

1.18 The EM refers to the *Health Insurance Amendment (Extended Medicare Safety Net) Act 2014*, which increased the EMSN annual threshold for non-concessional families and singles from $1,248.70 to $2,000, from 1 January 2015. The EM stated that, while this change would slow expenditure growth, it would not resolve fundamental structural problems within the program. For example, some families and singles reach the annual threshold early in the calendar year, due to the unlimited amount of out-of-pocket costs that can accumulate to the threshold.[18]

2014–15 Budget

1.19 In the 2014–15 Budget, the Government announced that, from 1 January 2016, the OMSN, the EMSN and the Greatest Permissible Gap would be replaced by a new Medicare Safety Net.[19]



Source: Australian Government, Budget Overview, 2014, p. 13.

1.20 The Government estimated that the proposed measure would achieve $266.7 million in savings over five years, by simplifying Medicare safety net arrangements.[20] This estimate was reiterated in the EM and in evidence to the committee.[21]

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17 CHERE, *Extended Medicare Safety Net, Review of Capping Arrangements Report 2011*, 2011, p. 5.

18 EM, p. 2.

19 Australian Government, *Budget measures: budget paper no. 2: 2014–15*, 2014, p. 145, http://www.budget.gov.au/2015-16/content/bp2/html/bp2_expense-15.htm (accessed 20 November 2015).

20 Australian Government, *Budget measures: budget paper no. 2: 2014–15*, 2014, p. 145.

21 EM, p. 7; Ms Maria Jolly, First Assistant Secretary, Medical Benefits Division, Department, *Committee Hansard*, 16 November 2015, p. 37. Also see: Associate Professor Kees Van Gool, Deputy Director, CHERE, *Committee Hansard*, 16 November 2015, p. 9, who indicated that the estimated savings may be low due to the unknown impact of a generic cap on services.

Key features of the Bill

1.21 The Bill would introduce the new Medicare Safety Net from 1 January 2016. The new Medicare Safety Net would be similar to the EMSN in that it would continue to provide an additional rebate to families and singles whose out-of-pocket costs for out-of-hospital Medicare services reach an annual threshold.[22] The proposed safety net would have the following features:

- the rebate would cover up to 80 per cent of out-of-pocket costs, subject to a new cap (150 per cent of the MBS fee less the general Medicare rebate); and
- there would also be a limit on the total amount of out-of-pocket costs for an out-of-hospital Medicare service that can be included in the calculation of the annual threshold.[23]

1.22 In addition:

> Families will still be able to pool their out-of-pocket costs and there will be a lower threshold for concession card holders and an intermediate threshold for families eligible for [Family Tax Benefit Part A (FTB(A))] and singles that are 'confirmed singles' or are 'FTB(A) persons'. A number of rules are being changed to improve administration of the programme for families.[24]

Key provisions and features

1.23 The key provisions of the Bill are contained in Part 1 of Schedule 1.[25] Some of these provisions and their corresponding features are:

- item 6 removes the Greatest Permissible Gap;
- item 7 removes the OMSN and EMSN and replaces them with the new Medicare Safety Net (proposed Division 3 of Part II–Medicare Benefits);
- proposed Subdivision D of Division 3 provides for the safety net threshold, including specifying the threshold that would apply to concessional people ($400), an FTB(A) person, a person confirmed as a member of an FTB(A) family or a confirmed single ($700), and an unconfirmed single or a person confirmed as a member of a family ($1,000) (proposed section 10DC);
- proposed Subdivision P of Division 3 provides for the expenses for a service that can accumulate toward the threshold—that is, the expenses are either out-of-pocket costs or, if these exceed the 'maximum amount to be included in safety net expenses for the service', then no more than that cap. A formula is provided for calculation of the cap which includes a 150 per cent cap (proposed section 10P);

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22 EM, p. 2. The Health Insurance Amendment (Safety Net) Bill 2015 (Bill) removes the concepts of the OMSN and Greatest Permissible Gap from the safety net arrangements.

23 EM, p. 1.

24 EM, p. 2. For a summary of the new streamlined arrangements, see Department, *Submission 18*, pp 1 and 5.

25 Part 2 of Schedule 1 to the Bill contains one application provision only.

- proposed Subdivision R of Division 3 sets out the methodology for calculating the benefit amount, so that the rebate is either the 'adjusted expenses' for a particular service or the 'maximum safety net amount', the formula for which includes a cap of 150 per cent (proposed section 10R); and
- proposed Subdivision S deals with indexation matters—that is, the annual threshold would be indexed on 1 January each year in accordance with the Consumer Price Index (proposed section 10S).[26]

1.24 A table in the EM sets out the key changes to these program parameters, together with examples of how the accumulation of out-of-pocket costs and the amount of the rebate would be calculated under the new Medicare Safety Net.[27] Examples of the new Medicare Safety Net calculations are provided also in the Department of Health's submission to the inquiry.[28]

Consideration by committees

1.25 The Senate Standing Committee for the Scrutiny of Bills considered but had no comment on the Bill.[29]

1.26 The Parliamentary Joint Committee on Human Rights (PJC–HR) has also considered the Bill. In its *Thirtieth Report of the 44th Parliament*, the PJC–HR considered that the changes to Medicare may limit the right to social security and the right to health (Articles 9 and 12, respectively, of the International Covenant on Economic Social and Cultural Rights (ICESCR)).[30]

1.27 The committee accepted that the Bill seeks to achieve a legitimate objective for the purposes of international human rights law—that is, better targeting of the safety net arrangements and ensuring that these arrangements are financially sustainable.[31] However, on the question of proportionality, the committee referred to the explanation of the measure's impact, as contained in the EM's Statement of Compatibility with Human Rights (Statement of Compatibility):

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26 The EM contains further information regarding all provisions proposed in Part 1 of Schedule 1 to the Bill.

27 EM, pp 4–5.

28 *Submission 18*, Attachment A, pp 25–27.

29 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest No. 12 of 2015*, 11 November 2015, p. 13, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Scrutiny_of_Bills/~/link.aspx?_id=9C088A1D713D4E768F32DA7371EA43D0&_z=z (accessed 20 November 2015).

30 Parliamentary Joint Committee on Human Rights (PJC–HR), *Thirtieth Report of the 44th Parliament*, 10 November 2015, p. 15, http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/Completed_inquiries/2015/Thirtieth_Report_of_the_44th_Parliament (accessed 20 November 2015).

31 EM, Statement of Compatibility with Human Rights (Statement of Compatibility), p. 9.

> The Commonwealth will continue to provide an additional rebate for out-of-hospital medicare services once the threshold has been reached…
>
> While the average benefit paid under the new medicare safety net will reduce, the number of people that will receive a safety net benefit will increase compared to the number of people who will receive a benefit under the EMSN in 2015. It is anticipated that benefits under the new medicare safety net will be more equitably distributed between socio-economically advantaged and disadvantaged areas. Currently, the EMSN disproportionally directs benefits to people living in more advantaged areas and encourages fee inflation. This fee inflation disadvantages people who do not qualify for safety net benefits.
>
> The new medicare safety net threshold for people who qualify for a Commonwealth concession card is lower than under the EMSN. Therefore this Bill protects the benefits of individuals that are financially disadvantaged.[32]

1.28 The committee reported that the position of financially disadvantaged people does not appear to have been considered in the Bill. The committee also reported that the Statement of Compatibility contains no information regarding how many financially disadvantaged people will be worse off as a result of the changes and what safeguards exist to ensure that such people are not barred from accessing appropriate out-of-hospital medical services due to a reduction in benefits.[33]

1.29 In summation, the committee questioned whether the measure proposed in the Bill is a justifiable limitation on the rights contained in Articles 9 and 12 of the ICESCR. The Minister has been requested to advise whether the limitation is a reasonable and proportionate measure for the achievement of the objective, with particular reference to the position of financially vulnerable people.[34] At the time of writing, the PJC–HR has not published a response from the Minister.

Conduct of the inquiry and acknowledgement

1.30 Details of the inquiry, including links to the Bill and associated documents, were placed on the committee's website.[35] The committee also wrote to 11 individuals and organisations, inviting submissions by 19 November 2015. The committee received 29 submissions, which are listed at Appendix 1. All submissions were published on the committee's website.

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32 EM, Statement of Compatibility, pp 9–10.

33 PJC–HR, *Thirtieth Report of the 44th Parliament*, 10 November 2015, pp 17–18.

34 PJC–HR, *Thirtieth Report of the 44th Parliament*, 10 November 2015, p. 18.

35 See: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs (accessed 20 November 2015).

1.31 The committee held a public hearing in Canberra on 16 November 2015. A list of witnesses who appeared at the hearing is at Appendix 2, and the *Hansard* transcript is available through the committee's website. References in this report to the *Hansard* are to the proof *Hansard*, and page numbers may vary between the proof and the official *Hansard* transcript.

1.32 The committee thanks those individuals and organisations who made submissions and who gave evidence at the public hearing.