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Health and Other Services (Compensation) Legislation Amendment Bill 2001

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Health and Other Services (Compensation) Legislation Amendment Bill 2001

Date Introduced: 30 August 2001

House: House of Representatives

Portfolio: Health and Aged Care

Commencement: The main provisions of the Bill (Schedules 1 and 2) commence on a day to be fixed by Proclamation or failing that six months from Royal Assent. The commencement of Schedule 3, which deals with the legal review of administrative decisions, is affected by the commencement date of the Administrative Review Tribunal Bill 2001 and related Bills. If these latter Bills do not come into force, neither will Schedule 3.

Purpose

To amend the *Health and Other Services (Compensation) Act 1995* and the *Health and Other Services (Compensation) Care Charges Act 1995* in order to reduce the administrative burden imposed under the current recovery regime. The Bill proposes to reduce the administrative burden on all parties, including the Health Insurance Commission, insurers and claimants, while ensuring that the Commonwealth can continue to identify and recover debt owed to it by successful claimants.

Background

The issue of how best to deal with the likelihood of 'double dipping' by successful claimants for compensation[1] has been of concern to the Commonwealth for many years. Double-dipping occurs when a person receives a compensation payment to cover medical and other care costs relating to their injury and does not reimburse the Commonwealth for any services received that have been subsidised under Medicare and/or benefits provided under other Commonwealth programs such as residential care.[2] In these situations, the claimant has been compensated twice for medical costs associated with the injury. It has been argued that:

> double dipping can never be acceptable, because it means that the community pays twice for a service–once through insurance and again through Commonwealth funding.[3]

Long-standing provisions in the *Health Insurance Act 1973* and the *National Health Act 1953* were seen to be ineffective in the recovery of monies owed to the Commonwealth in these situations,[4] resulting in the passage, with bipartisan support, of the *Health and Other Services (Compensation) Act 1995* (the Act), which took effect from 1 January 1996. Passed also were the accompanying *Health and Other Services (Compensation) Care Charges Act 1995* and the *Health and Other Services (Compensation) (Consequential Amendments) Act 1995*. However, the regulatory regime introduced by this legislation proved cumbersome. A much larger than predicted caseload and implementation problems resulted in long delays for many claimants in receiving their compensation payments, even in situations where little or no debt was actually due to the Commonwealth.

In an effort to improve the effectiveness of the recovery scheme, consultations were conducted between government, insurers and lawyers, resulting in amendments to the Act which were contained in the *Health and Other Services (Compensation) Amendment Act 1996.* As was the case with the original Act, this piece of legislation passed with bipartisan support. The principal effect of the amendments was to enable the immediate payment to claimants of 90 per cent of their settlement, with any remainder paid after the Health Insurance Commission recovered any 'double-dipped' benefits.

Despite the bipartisan support of the Parliament, both the original Act and the 1996 amendments attracted considerable opposition from insurers and lawyers. As a result, the Government and Opposition gave a commitment that the scheme would be reviewed after 12 months of operation.[5] The former Insurance and Superannuation Commissioner, George Pooley, was appointed in March 1999 to conduct a review of the Act and the operation of the Compensation Recovery Program, which is administered by the Health Insurance Commission. The report of the Review was tabled following the introduction of the Health and Other Services (Compensation) Legislation Amendment Bill 2001 (the Bill).

The Review found that the Act 'had many shortcomings and should not be continued in its present form' and identified a preferred option for improving the effectiveness and efficiency of the recovery scheme.[6] This preferred option is embodied in the amendments contained in the Bill and is discussed as Option 2 in the Explanatory Memorandum to the Bill.[7]

A key shortcoming of the Act was found to be its administrative complexity which resulted in almost 50 per cent of benefits recovered by the Commonwealth being subsumed by administrative costs associated with the recovery process. For example, in 1998-99, the Health Insurance Commission recovered $31.9 million under the Compensation Recovery Program, but at an administrative cost of $14.7 million.

The Government announced in the 2001-02 Budget that it intended to amend the Act to streamline the operation of the Compensation Recovery Program. This is expected to result in annual savings of approximately $6.5 million accruing to the Commonwealth and may assist also to reduce pressure on insurance premiums through streamlining of administrative costs and procedures for insurers and workers' compensation authorities.[8]

A major reform proposed by the Bill is to exempt from the operations of the Act and the Compensation Recovery Program all compensation claims of less than $5000. It is expected that this change will result in a significant reduction in the number of settlements and judgements that must be notified to the Health Insurance Commission, with attendant savings in administrative costs.

The threshold of $5000 was selected because it has been estimated by consultants to the Review that the Health Insurance Commission makes a loss recovering payments on cases with judgments/settlements below $5000. The consultants estimate that the effect of exempting judgements/settlements of less than $5000 would be to reduce the number of cases reported to the Health Insurance Commission by 21 per cent (amounting to around 30 000 cases in 1998-99). Although this measure would reduce gross revenue to the Commission by some $5.7 million (about 10 per cent of gross revenue) it would also reduce the costs to the Commission by 21 per cent ($6.4 million), resulting in an increase in net revenue to the Health Insurance Commission of $0.7 million.[9]

The Bill also proposes to eliminate potential judgements or settlements from the current notification requirements imposed by the Act. This measure is likely also to result in administrative savings for all parties because many claims notified to the Health Insurance Commission under the current regime do not actually proceed to judgement/settlement.[10]

An indication of the necessity for reform of current arrangements can be gauged from the assessment of the Review that the Compensation Recovery program is:

> complex, convoluted and enormously expensive to administer for all the parties involved. The process is largely a function of HOSCA [the Act] itself. It was well said that a complex Act leads to complex administration with unnecessarily high costs to most or all of the stakeholders.[11]

Main Provisions

Item 2 of Schedule 1 inserts an additional paragraph in subsection 4(2). This subsection describes the types of payments that are not regarded as compensation for the purposes of the Act. The **proposed new paragraph** will permit a Regulation to be prescribed that will widen the types of payments not regarded as compensation for the purposes of the Act. For example, it will enable the exclusion from the Act of any sections of State and Territory legislation that, while not included at present, may at some point in the future be caught by provisions of the Act.

Notification of a claim for compensation

Item 6 of Schedule 1 repeals sections 11 and 12, both of which relate to the notification of a claim for compensation. As discussed above, notification to the Health Insurance Commission of a claim prior to judgement/settlement will not be required under the new streamlined recovery process. Rather, notification will be required only after a judgement or settlement has been reached. **Proposed new section 11** relates to the operation of Division 1, clarifying that the Division will operate if a person makes a claim against another person for compensation in respect of an injury.

Items 3 and 5 of Schedule 1 repeal paragraphs 8(9)(a) and 10(9)(a) respectively, both of which are consequential amendments taking account of the repeal of sections 11 and 12. **Item 26 of Schedule 1** omits the words '11, 12 or' from section 29(3) because of the proposed repeal of sections 11 and 12. **Items 37 to 39 of Schedule 1** propose consequential amendments to take account of the proposed repeal of sections 11 and 12. **Items 1 and 2 of Schedule 2** repeal paragraphs 6(9)(a) and 8(9)(a) respectively. Both paragraphs refer to and are dependant upon sections 11 and 12.

Item 7 of Schedule 1 repeals section 13 which also relates to notification of a claim for compensation and refers to sections 11 and 12, both proposed for repeal. **Proposed new section 13** maintains the current requirement for notification of a reimbursement arrangement if it is entered into 6 months or more after a claim for compensation is made. Also maintained is the period of 28 days in which a person who is liable to reimburse a claimant must notify the Health Insurance Commission of the arrangement.

Item 8 of Schedule 1 repeals sections 15 and 16 which relate to the notification of claims which fail or are discontinued or where a claim is unlikely to become active again. The provisions of these sections become redundant under the new streamlined recovery process that does not require notification of claims prior to judgement/settlement. **Items 20 to 25 of Schedule 1** remove references to section 15 and also to sections 11 and 12 because of the proposed repeal of these sections.

Statements by claimants for compensation

Items 9 to 15 and **items 17 to 19 of Schedule 1** relate to statements by claimants for compensation. These statements specify any services received by the claimant where a Medicare benefit has been paid and/or whether residential care services have been provided in the course of treatment of, or as a result of, the injury the claimant claims to have suffered. The statements are called 'Statements of past benefits'. **Proposed sections 23B, 23C and 23D** are inserted by **item 17 of Schedule 1**. These new sections relate to cases where a statement of past benefits lodged by a claimant is regarded as not substantially correct by the Managing Director of the Health Insurance Commission. **Items 32 to 36 of Schedule 1** relocate several sections to **proposed new sections 23B to 23D** and also amend further sections to take account of the relocated sections. **Item 43 of**

Schedule 1 provides for the operation of transitional provisions in relation to the relocation of these sections.

Advanced payment option

The advanced payment option was inserted in the Act by the *Health and Other Services (Compensation) Amendment Act 1996*. This option permits the immediate payment to claimants of 90 per cent of their settlement, with any remainder paid after the Health Insurance Commission recovers any 'double-dipped' benefits. **Item 28 of Schedule 1** inserts **proposed section 33AA** to provide for a sunset provision that will remove the advanced payment option. The sunset provision is proposed to commence on 1 July 2004 or a later date, but no later than 1 July 2006, as determined in writing by the Minister.

The Review of the Act and the Compensation Recovery Program undertaken by George Pooley considered whether the advanced payment arrangements should continue to operate. The arrangements were introduced originally as a temporary measure to deal with the backlog of cases that built up under the initial recovery regime that commenced on 1 January 1996. The second reading speech indicates that the streamlined processes envisaged under the provisions of this Bill, together with earlier streamlining mean that the advanced payment arrangements should be removed with effect from 1 July 2004.[12]

Item 31 of Schedule 1 inserts **proposed subsection 33B(2A)** which provides greater flexibility to current arrangements by enabling the Minister to determine different amounts, or ranges of amounts, of compensation payable under the advanced payment option. Provisions will enable the Minister to set different percentages for any one or more of the altered amounts of compensation.

The report of the Review found that, in most cases, the retention by the Health Insurance Commission of 10 per cent of each compensation payment far exceeds the amount which is repayable to the Commonwealth for Medicare and other benefits. The average across all cases between 1997-1999 was found to be 2.1 per cent. The Review found also that the greater the size of the compensation payment, the lower the proportion of the claim required to be repaid to the Health Insurance Commission. The Review recommended that a sliding scale be established for the Advanced Payment Option arrangements whereby for judgements/settlements between $5000 to $10 000, the Advanced Payment Option would be 5 per cent. For judgements/settlements of $10 000 to $50 000 the amount would be 3 per cent and for judgements/settlements in excess of $50 000, the Advanced Payment Option would be 1 per cent.[13]

A proposed new threshold of $5000

Items 30 and 40 of Schedule 1 propose to set a threshold of $5000, amounts below which will be defined as 'small amounts'. This will enable all compensation judgements/settlements below $5000 to be exempt from the Act. As discussed above, this

will remove about 30 000 claims per annum from assessment by the Health Insurance Commission, resulting in considerable administrative savings. The Review of the Act and its operations found that it cost the Commission more to administer claims below $5000 than it recovered in payments.

Concluding Comments

In making its recommendation of a preferred option, the report of the Review concluded that all stakeholders[14] supported a proposal to establish a committee of stakeholders to consider the pros and cons of the development of a national database for compensation cases and for the development of a system for 'tagging'[15] medical services, especially those associated with compensation injuries.[16] Neither the second reading speech nor the explanatory memorandum of the Bill contain any indication of the Government's views on these proposals. The report of the review noted that a proposal to establish a national database of workers' compensation injuries is being developed for the consideration of Commonwealth and State Workplace Relations Ministers.[17] In addition, proposals for the development of unique patient identifiers and individual electronic health records have been under active consideration, however any implementation would appear, at this stage, to be well into the future.

Endnotes

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1 The report of the Review of the Act by George Pooley indicates that under the Act, Medicare payments for services are recovered for claims for compensation made under common law, public liability, workers' compensation or third party (motor vehicle accident) compensation. Medicare payments for services are not recoverable where claims for compensation are made for criminal injuries compensation. In cases involving sporting injuries or school accidents, the operation of the Act is less clear and recovery of Medicare payments depends on the type of claim and insurance status of the claimant. (G Pooley, *Review of the Health and Other Services (Compensation) Act 1995 and of its operation*, Canberra, 2001, p. 23.)

2 Pooley, p. 22.

3 House of Representatives, *Debates*, 19 August 1994, p. 4453.

4 Pooley, *op cit*, p. 22.

5 Pooley, p. 23.

6 Pooley, p. 86.

7 see, for example, Explanatory Memorandum, p. 6.

8 *Budget Paper No.2, 2001–02*, p. 147.

9 Pooley, *op cit*, pp.33–34.

10 Pooley, p. 24.

11 Pooley, p. 24.

12 House of Representatives, *Debates*, 30 August 2001, p. 30333.

13 Pooley, *op cit*, p. 36.

14 It is worth noting that consumers were not represented directly on the Committee of Stakeholders established to assist the Review process. Although the Review called for public submissions, none were received from representatives of consumers.

15 This proposal would require medical practitioners and other providers of health care services to attach a code or electronic tag to their bills to Medicare so that the Health Insurance Commission can quickly recognise medical services arising from a compensable injury. Such a system would enable the Commission to monitor the pattern of services provided by doctors to compensable patients. The report of the Review argues that as a result of the Commission being aware at an early stage of the provision of services for a compensable injury, injuries may be treated more efficiently and claimants may be returned to work more rapidly, with a reduced need for economic compensation (Pooley, p. 84).

16 Pooley, p. 86.

17 Pooley, p. 85.