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Health Insurance Amendment (Compliance) Bill 2010

Mandy Biggs & Anne-marie Boxall
Social Policy Section
Sharon Scully & Juli Tomaras
Law and Bills Digest Section

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Health Insurance Amendment (Compliance) Bill 2010

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House: House of Representatives

Portfolio: Health and Ageing

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Links: The links to the Bill, its Explanatory Memorandum and second reading speech can be found on the Bills home page, or through http://www.aph.gov.au/bills/. When bills have been passed they can be found at the ComLaw website, which is at http://www.comlaw.gov.au/.

Note: This Bill is the reintroduction of the Health Insurance Amendment (Compliance) Bill 2009 that was introduced in the 42nd Parliament on 17 September 2009. The Bill lapsed at the proroguing of Parliament. The Bills Digest prepared for the original Bill remains relevant and accurate except that it does not discuss amendments agreed to and rejected in the previous Parliament. This Bills Digest updates the original one by adding a discussion in the Background section about the amendments proposed to the 2009 Bill. The amendments agreed to are contained in this Bill.

Purpose

The Health Insurance Amendment (Compliance) Bill 2010 (the Bill) proposes to amend the *Health Insurance Act 1973* (the Act) in order to implement the Increased Medicare Compliance Audits (IMCA) initiative, which was previously announced in the 2008–09 budget.

The IMCA initiative includes an increase in the number of Medicare compliance audits undertaken and a proposal to increase the powers of Medicare Australia (MA) to compel doctors to present documents to substantiate their Medicare billing claims.[1]

Background

Medicare expenditure has grown substantially in recent years to $14 billion per year—more than doubling over the last ten years.[2] Compliance audits undertaken by Medicare Australia (MA)

1. N Roxon (Minister for Health and Ageing), J Ludwig (Minister for Human Services), *Ensuring the integrity of Medicare: increased MBS compliance audits,* media release, 13 May 2008. The number of audits will increase from 500 to 2500 per year.
2. In 1997–98 Medicare expenditure was $6.3 billion. See Department of Health and Family Services, *Annual report 1997–98,* the Department, Canberra, p. 77.

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administrative staff are an established mechanism for maintaining the integrity of Medicare through identifying incorrect Medicare claims.[3] The audit process focuses on identifying incorrect claiming or billing of Medicare items by health providers through analysis of claiming data. A Medicare compliance audit has been described as:

> … an administrative check that ensures the provider and patient were eligible for the Medicare benefits already received; the service was provided and that it met the MBS item requirements which correspond to the claim that has been made.[4]

Where the audit process raises concerns over a medical practitioner's clinical practice (such as a clinical practice considered unacceptable by members of the medical profession), MA may refer the practitioner to the independently convened Professional Services Review Board (PSR) for review.

It should be noted that the PSR process is separate to the audit process which as noted, focuses on inappropriate billing or claiming. The PSR considers cases of possible inappropriate clinical practice using a peer review process. In 2007–08, MA referred 50 matters to the PSR for review.[5]

While the majority of practitioners cooperate with the Medicare compliance audits, the Government estimates that around 20 per cent do not by either refusing to cooperate or not responding to any requests for documents.[6] An Australian National Audit Office (ANAO) report found that non-compliant Medicare payments equated to around 1.3 to 2.3 per cent of expenditure in 1996–97. Given the subsequent growth in Medicare expenditure, MA estimates that annual non-compliant payments range from $170–$300 million per annum.[7] Furthermore, where non-compliance is identified, only a small portion of incorrect claims are ever recovered (without sanction)—a situation which fails to provide adequate deterrence.[8]

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3. Compliance audit activities are permitted under sections 5 and 6, and Part IID of the *Medicare Australia Act 1973*; and section 4 of the Medicare Australia (Functions of the Chief Executive Officer) Direction 2005. Medicare Australia has recently released its Medicare Compliance Program for 2009–10 detailing its planned activities for the year ahead. See, http://www.medicareaustralia.gov.au/provider/business/audits/files/national-compliance-program-2009-2010.pdf
4. Medicare Australia, 'Supplementary Submission to the Senate Community Affairs Committee Inquiry into Compliance, http://www.aph.gov.au/Senate/committee/clac_ctte/medicare_benefits_compliance_audits/submissions/sub16c.pdf
5. Professional Services Review, *Annual report 2007–08,* Canberra, PSR, 2008, p. 7.
6. C Bowen, *Legislation introduced as part of Increased Medicare Compliance Audits Initiative*, media release, 17 September 2009.
7. Medicare Australia, *Medicare Australia's Submission to the Public Affairs Committee on Medicare Compliance Audits*, p. 12, dated 24 April 2009, viewed 23 September 2009, http://www.aph.gov.au/Senate/committee/clac_ctte/medicare_benefits_compliance_audits/submissions/sub16.pdf
8. Ibid., p. 26.

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Unlike the PSR process where examination of clinical records is authorised,[9] MA cannot compel doctors to produce documents, such as clinical records, to substantiate their billing practices.[10]

As part of its Responsible Economic Management policy agenda for the 2008–09 Budget, the Government announced the IMCA initiative, including an increase of the number of Medicare compliance audits undertaken from 500 to 2500 per year. This part of the initiative commenced in January 2009. The Budget also included an announcement that the Government proposed to increase the powers of MA to compel doctors to present documents to substantiate their Medicare billing practises.[11] In undertaking this latter proposal, the Government promised a consultation process with stakeholders would be undertaken during 2008–09.

Subsequently, during the latter half of 2008, consultations with peak medical and allied health and consumer groups commenced. The Government also sought advice from the Office of the Privacy Commissioner. The result of this consultation process was the formulation of draft legislation in April 2009 and the preparation of a Privacy Impact Assessment (PIA); both the draft legislation and the PIA were subsequently referred to a Senate Committee for inquiry (see below for more details).

The Government developed a final legislative package, in response to stakeholder feedback and the Senate Committee inquiry. A number of amendments to the 2009 Bill were proposed when it was introduced into Parliament. The section below outlines which were agreed and which were rejected before the Bill lapsed.

Agreed amendments

A total ten amendments to the 2009 Bill were proposed in the Senate. Eight of them (amendments 2 to 9, all of them proposed by the Opposition) were agreed to in both the Senate and House of Representatives. Details of these amendments can be found here, but in brief they:

- require the CEO of Medicare Australia to consult with relevant professional bodies about the type of documents that would be relevant for substantiating claims;
- define what a relevant body is in the context of the legislation;
- provide greater clarity about issuing notices to people regarding Medicare claims;

9. Part VAA of the *Health Insurance Act 1973* authorises PSR Committees (comprising medical practitioners) to require the production of documents including clinical records.
10. With the exception of section 8P of the *Medicare Australia Act 1973,* which sets out an information and document gathering power where there are reasonable grounds for believing that particular criminal offences have been committed or particular civil contraventions have occurred. Medicare Australia, *Medicare Australia's sub mission to the Senate Community Affairs' inquiry into the Compliance Audits on Medicare Benefits*, [24 April 2009], p. 19, viewed 22 September 2009, http://www.aph.gov.au/Senate/committee/clac_ctte/medicare_benefits_compliance_audits/submissions/sub16.pdf
11. N Roxon (Minister for Health and Ageing), J Ludwig (Minister for Human Services), *Ensuring the integrity of Medicare: increased MBS compliance audits,* media release, 13 May 2008. The number of audits will increase from 500 to 2500 per year.

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- prevent the CEO from raising questions about the clinical relevance of particular services; and
- provide greater clarity about the process of reviewing decisions made by the CEO about Medicare claims.

The eight amendments agreed to by the 42nd Parliament are included in this Bill, with some minor changes that do not alter their meaning.

Rejected amendments

Two amendments to the 2009 Bill (amendments 1 and 10, proposed by the Opposition, Family First Party and Senator Xenophon) proposed in the Senate were rejected by the House of Representatives. The Senate insisted on these amendments and the House insisted on disagreeing. Details of these amendments can be found here, but in brief:

Rejected amendment number 1 relates to dates of commencement, which does not significantly advance the object and purpose of the Bill or proposed amendments, in any substantive way.

The second rejected amendment (number 10) relates to section 4 of the Act. Section 4 of the Act deals with the general medical services table. The subsection 4(1) provides that the regulations may prescribe a table of medical services (other than diagnostic imaging services and pathology services) that sets out the following:

(a) items of medical services

(b) the amount of fees applicable in respect of each item

(c) rules for interpretation of the table.

It was proposed to add at the end of subsection 4, the following amendment

(3) If an item in a table of medical services prescribed in accordance with subsection 4(1) is disallowed under section 42 of the *Legislative Instruments Act 2003*, the corresponding item, if any, in the previous regulations, is taken to apply in place of the disallowed item from the time of disallowance.

corresponding item means:

(a) the item in the previous regulations with the same item number; or

(b) if no item satisfies paragraph (a)—the item in the previous regulations covering the same medical services;

as the disallowed item.

previous regulations means the regulations that were in force immediately prior to the commencement of the disallowed item.

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The Government's response that this proposed amendment has no substantial relationship with this Bill does not seem to be an adequate objection. The amendment fits within the broad theme of the Bill relating to items and fees for medical services.

The Government has further stated that:

> The Government has a fiscal responsibility to manage the budget in a sustainable way that provides the best outcome for the taxpayer. This amendment could hinder the Government's ability to ensure sustainability of the medical benefits program in the face of population ageing and growth in the costs of medical technology, prevent the reinvestment of appropriate dividends from progress in medical technology and practice towards needed health reforms and otherwise undermine the Government's ability to deliver the best outcome for the taxpayer.[12]

It is unclear as to how such an amendment may have such adverse and non-beneficial consequences as the Government suggests.

What is perhaps more compelling is the Government's argument and advice relating to the retrospective operation of the proposed amendment.

> These amendments are also intended to act retrospectively from 26 October 2009. This is clearly intended to have an effect of increasing the Medicare Benefits Schedule (MBS) fee for items disallowed by the Senate on 28 October 2009. Legal advice to the Government confirms that this effectively would be increasing a standing appropriation and would be construed as appropriating money. Thus, these amendments must be considered to be unconstitutional as contrary to s.53 of the Constitution, which provides inter alia that:
>
> *Proposed laws appropriating revenue or moneys or imposing taxation shall not originate in the Senate;* and
>
> *The Senate may not amend any proposed law so as to increase any proposed charge or burden on the people*.[13]

Key changes in this Bill

Broadly, this Bill proposes:

- to enable the Chief Executive Officer (CEO) of MA, where a reasonable concern exists, to issue a notice to a medical practitioner (or others) to produce documents within a specified time, that may include patient medical records, to substantiate whether a Medicare benefit paid for a professional service exceeded the proper amount

12. Health Insurance Amendment (Compliance) Bill 2009, Schedule of the amendments made by the Senate to which the House of Representatives has disagreed, 24 November 2009.
13. Ibid.

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- that where documents are required to substantiate a Medicare claim, the CEO must consult with a medical adviser who is an employee of MA concerning the type of documents required and who is the only person authorised to view patient clinical details
- that clinical records are not required to be produced unless these would be necessary to substantiate a claim
- that the CEO give the person issued with a notice to produce documents a reasonable opportunity to respond
- allows for the imposition of civil penalties where those issued with a notice on behalf of a medical practitioner, fail to comply, except where it is beyond their control to do so
- that where documents are produced, they are not admissible in evidence in criminal or civil proceedings, except in certain cases relating to false or misleading statements, and the practitioner cannot claim self-incrimination as a defence against producing documents
- debt notice and recovery processes with specified time periods between the notice of a decision and a notice claiming the debt
- an internal review process of debt decisions, and
- administrative penalty amounts designed to deter non-compliance and recidivist behaviour

The Government estimates the measures contained in the IMCA initiative, including the proposals contained in the Bill, will result in total savings of $147.2 million over four years, with administration costs of $76.9 million, resulting in net savings of $70.3 million.[14]

Basis of policy commitment

As noted above, the Bill proposes to implement a 2008–09 budget measure as part of the Government's 'responsible economic management' policy agenda.

Committee consideration

The current Bill has not been referred to a Parliamentary Committee.

However, a draft exposure Bill circulated in April 2009 was referred to the Senate Community Affairs Legislation Committee (the Committee) for inquiry, by Senator Ludwig, Minister for Human Services.[15]

The Committee's inquiry examined the draft legislation and associated explanatory material, as well as the PIA.[16] The Committee received some 25 submissions and took evidence from a range of peak stakeholder and consumer groups. A number of issues were raised, including (but not confined to):

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14. Explanatory Memorandum, Health Insurance Amendment (Compliance) Bill 2010, p. 3.
15. For details of this inquiry, see Senate Community Affairs Legislation Committee, *Compliance audits on Medicare benefits*, The Senate, Canberra, 2009, p. 1, viewed 22 September 2009, http://www.aph.gov.au/Senate/committee/clac_ctte/medicare_benefits_compliance_audits/index.htm

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- privacy and the doctor/patient relationship—a number of medical and other groups raised concerns that some patients might withhold information from their doctors if they were aware that their personal information could be shared with third parties for purposes other than medical care. In particular, the Australian Society for HIV Medicine stressed the importance of maintaining confidentiality, particularly where information is of an intimate nature.[17] The Office of the Privacy Commissioner suggested that MA consider the use of medical advisors in handling clinical information[18]
- lack of clarity concerning access to clinical records and substantiation of claims—some medical groups, such as the Australian Psychological Society, cited a lack of clarity regarding the type of documents that might be required. AMA argued that in most cases clinical records would need to be produced as administrative records are lacking in sufficient detail[19]
- concerns over patient notification and consent—a number of consumer and medical groups raised concerns over the disclosure of patient medical records without patient's consent being sought or notification given. The Private Mental Health Consumer Network called on MA to develop 'clear protocols' for practitioners. Others such as the Public Interest Advocacy Centre (PIAC) recognised that seeking such consent or giving notification may cause unnecessary stress to patients, and be impractical[20]
- MA staff and protection of confidentiality—stakeholders also expressed concern that administrative staff were not suitably qualified to interpret medical records or clinical data. The Australian Privacy Foundation's Dr Roger Clarke noted clinical data was 'easy to misinterpret'. Further concerns were also raised about the confidentiality of patient records and the capacity of current measures to secure such information[21]
- duplication of work undertaken by the PSR—a number of groups suggested the proposed measures may duplicate the review work already undertaken by the PSR. Civil Liberties Australia expressed concern over the 'blurring of lines between the proposed compliance audit process and the existing PSR process'. The Medical Indemnity Industry Association (MIIA) noted that appropriate accountability mechanisms 'already existed'[22]
- cost impact on practitioners and complexity—a number of stakeholders pointed to the additional cost and administrative burden on practitioners, and questioned the accuracy of the cost estimates contained in the draft explanatory materials. The Australian College of General Practitioners suggested the complexity of Medicare and the Pharmaceutical Benefits Scheme sometimes led to 'unavoidable errors' and that simplification of these programs combined with education of providers was a better approach to the problem of non-compliance[23]
- integrity of Medicare and the public interest—some stakeholders supported the proposed changes. The Australian Health Insurance Association noted they were 'important to ensuring the integrity of Medicare' in light of the considerable public expenditure on the program.[24] PIAC

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16. Both the draft legislation and the PIA appear in the Appendices of the Committee's report.
17. Senate Community Affairs Legislation Committee, op. cit., p. 6.
18. Ibid., p. 7.
19. Ibid., p. 9.
20. Ibid., pp. 11–12.
21. Ibid., p. 13.
22. Ibid., p. 15.
23. Ibid., p. 16.
24. Ibid., p. 19.

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suggested the proposed changes raised two potentially competing public interest principles that need to be balanced: the principle of the public interest 'in the maintenance and integrity of Australia's universal health scheme' and 'the public interest in the confidentiality…in the doctor/patient relationship'[25]

- penalties and appeal processes—among the issues of concern raised by many groups were those regarding the process for appeal. The AMA was concerned over a lack of 'procedural fairness' with the scope and application of the proposed penalties. The MIIA argued in favour of an external merits review, while the Commonwealth Ombudsman raised concerns over the automatic nature of the penalty regime and noted that changes in medical practice and terminology could lead to cases of 'genuine confusion'.[26]

In its concluding comments, the Committee's report was broadly supportive of the draft legislation and the PIA. It considered that the draft legislation achieved a 'good balance' between the two competing public interest principles—that is, the interest of patients to have their medical records kept confidential and the interest of taxpayers who are entitled to expect 'reasonable checks are made' to ensure public funds are spent appropriately.[27] However, the Committee expressed some sympathy for concerns about penalties and appeals, and regarded arguments supporting a 'multi-stage audit process' as 'persuasive'.[28] It also agreed with a proposal made by the AMA that recordkeeping requirements be clarified.[29]

The Committee recommended that specific measures be detailed in regulations to the effect that patient clinical records are only required to be accessed where necessary.[30]

The substance of the Committee's recommendation was accepted by the Government, with the modification that it be addressed in the primary legislation, which this Bill now proposes.[31]

In a minority report, Opposition Senators broadly supported efforts to enhance and expand the audit process, but disagreed with the majority view that the draft legislation had achieved the right balance between patient privacy and ensuring public funds are appropriated properly. They made four recommendations: that a training and information program for GPs be developed, the Medicare Benefits Schedule be simplified, protocols for the protection of patient privacy be developed and that reviews of practitioners requiring patient records be referred to the PSR.[32] The Greens supported greater safeguards for patient privacy, including oversight by medical advisers and the making of a Privacy Impact Assessment.[33]

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25. Ibid., p. 17.
26. Ibid., p. 21.
27. Ibid., p. 24
28. Ibid., p. 25.
29. Ibid.
30. ibid., p. 26.
31. Explanatory Memorandum, op. cit., p. 1. See, for example, **proposed subsection 129AAD(8)**.
32. Senate Community Affairs Legislation Committee, op. cit., p. 33.
33. Ibid., p. 35.

Position of significant interest groups/press commentary

As noted, the development of the 2009 Bill was the result of an extensive consultation process, including the development of draft legislation and PIA; and referral of these to a Senate Committee. Notwithstanding the considerable debate that occurred around the draft legislation, there was minimal commentary regarding the 2009 Bill. Generally, the comments made were more positive than those made about the draft legislation.

The AMA has commended the Government for 'addressing concerns raised by the AMA in regards to the original Bill', such as ensuring that only medical practitioners employed by MA can view patient records, thus protecting patient privacy. In addition, the AMA welcomed the internal review provisions of the 2009 Bill and new arrangements that ensure that audits will only be undertaken where a 'reasonable concern' exists.

Coalition/Greens/Family First policy position/commitments

The Opposition and minor parties expressed some criticism of the draft legislation and proposed some amendments to the 2009 Bill (see above).[34]

Financial implications

The Government estimates that overall, the ICMA measure will result in total savings of $147.2 million over four years, and administration costs of $76.9 million, resulting in a net saving of $70.3 million.[35] Modest savings of $6.9 million are forecast for 2008–09, the first year of the ICMA initiative, with larger savings forecast over the forward years, reflecting the ramping up of the compliance audits. The cost estimates also allow for one-off related capital cost of $6.2 million—presumably to allow MA to purchase new equipment in order to implement the measure.

It should be noted that the forecast costs and savings remain unchanged from those contained in the draft legislation and announced in the 2008–09 Budget. This is despite the fact that the 2010 Bill contains new provisions that propose utilising medical advisors and allowing for an internal appeals process, measures which could be expected to have some cost impacts on MA.

The forecast costs and savings in the 2010 Bill remain unchanged from those announced in the 2008-09 Budget.

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34. As at 22 November 2010.
35. Explanatory Memorandum, op. cit., p. 3.

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Main provisions

Item 2 of the Bill proposes to **insert new sections 129AAD–129AAJ** into the Act. These proposed amendments effectively enable MA to enforce requirements on medical practitioners to produce certain documents during compliance audits.

Proposed section 129AAD would enable the CEO to give a written notice to produce documents to substantiate whether a Medicare benefit or payment that had been paid in respect of a particular professional service—should actually have been paid. The notice to produce would be issued to either the practitioner who had provided the professional service in question or someone who has custody, control or possession of the relevant documents.

Importantly, the CEO may only give a person such a notice if he or she has given that person a reasonable opportunity to respond to an earlier request (not under **proposed section 129AAD**) to produce the documents. This would ensure that:

> practitioners are provided with an opportunity to cooperate with Medicare Australia prior to a formal notice under the Act being issued. It means that practitioners who choose to voluntarily tell Medicare Australia that they have received a benefit that exceeds the amount they should have been paid still receive discounts on any financial penalty that may apply.[36]

In addition, the CEO may only issue such notice if he or she believes on *reasonable grounds* that:

- someone who had provided the professional service(s) in respect of which the amount—the subject of the CEO's concern—was paid; or on whose behalf the professional services was provided, or
- another person (not the patient nor anyone else who incurred expenses in respect of the professional services provided),

has possession, custody or control of documents relevant to substantiating the Medicare benefit or payment made in respect of the professional service(s).

It is noted that the purpose of including 'another person' with possession, custody or control of documents relevant to substantiating the Medicare benefit is to cater for corporate practices and hospitals contracting out to practitioners.[37] In addition:

> It aims to encourage third parties to cooperate with an audit request so that practitioners who do not control the relevant documents are able to substantiate services. It is also intended to discourage practitioners from establishing corporate structures in order to avoid compliance with a notice to produce documents issued under this legislation.[38]

36. Ibid., p. 6. In relation to discounts on financial penalties, see also **proposed subsection 129AEB(3)**.
37. Explanatory Memorandum, op. cit., p. 6.
38. Ibid.

The notice to produce documents is restricted to professional services given in a two year period immediately before the notice is issued and must give the person at least 21 days to comply. However, the effect of both **items 3** and **10** of the Bill would, arguably, preclude any retrospective application of this provision. The effect of **item 3** is that **proposed section 129AAD** would not apply in relation to professional services provided before the commencement of this provision. In addition, under **item 10**, the penalty provisions of **proposed sections 129AEA–129AEC** (see below) would not apply to professional services provided before the commencement of those sections.

It is noted that under **proposed subsections 129AAD(5)** and **(6)**, whereas the notice may require production of relevant documents or extracts of documents (or copies thereof) to the CEO or an MA employee, if the documents in question contains clinical details of an individual, the person to whom the notice was issued only has to produce those documents to an MA employee who is a medical practitioner. The Government assures that:

> Medicare Australia will have qualified medical practitioners available to receive documents in all audits.[39]

In addition, the Government states that:

> All medical practitioners employed by Medicare Australia are subject to the provisions of the *Public Service Act 1999* and the secrecy provisions in the *Health Insurance Act 1973*.[40]

It is also noted that only documents (or extracts thereof) which are *relevant* to the purpose of substantiating the Medicare benefit or payment made in relation to the specified service(s) need be produced. According to the Government:

> The relevancy test operates to ensure that once the person has provided information which substantiates the service, no further documents can be sought. This means that practitioners will not have to produce all parts of a document, or all documents relating to a service, and only need to produce enough information to address the CEOs concern and substantiate the service.[41]

It is also noted that **proposed subsection 129AAD(8)** stipulates that the notice must explicitly state that the person to whom the notice is given would not have to produce a document, extract or copy containing an individual’s clinical details unless it is necessary to substantiate an amount paid for a professional service.

Proposed subsection 129AAD(9) states that documents to be produced may also be documents containing health information as defined by section 6 of the *Privacy Act 1988* (the Privacy Act) as information about:

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39. Explanatory Memorandum, op. cit., p. 2.
40. ibid., p. 7. See, for example, *Health Insurance Act 1973* section 130 (officers to observe secrecy); *Public Service Act 1999* sections 13 and 14.
41. Explanatory Memorandum, op. cit., p. 7.

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> (i) the health or a disability (at any time) of an individual; or
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> (ii) an individual's expressed wishes about the future provision of health services to him or her; or
>
> (iii) a health service provided, or to be provided, to an individual;
>
> that is also personal information; or
>
> (b) other personal information collected to provide, or in providing, a health service; or
>
> (c) other personal information about an individual collected in connection with the donation, or intended donation, by the individual of his or her body parts, organs or body substances; or
>
> (d) genetic information about an individual in a form that is, or could be, predictive of the health of the individual or a genetic relative of the individual.

Under the Privacy Act, health information about a person is regarded as 'sensitive information' and subject to National Privacy Principles (NPPs), relating to the collection and disclosure of such information.[42]

Under **proposed subsection 129AAD(1)**, **proposed section 129AAD** would only apply if the CEO:

- has *reasonable concern* that a benefit or payment had been made under the Act in respect of one or more professional services, which may exceed an amount that should have been paid (if anything at all), and
- has considered advice from a Medicare employee who is a medical practitioner about what types of documents contain information relevant to substantiating that benefit or payment.

According to the Government:

> The requirement for the CEO to have a reasonable concern is included to ensure that compliance audits are not conducted on a random basis. Medicare Australia will use a range of sophisticated data analysis techniques as well as gathering information that is provided by members of the public in order to identify potential risks to the integrity of the Medicare scheme. The reasonable concern developed by the CEO is based on this analysis work.[43]

It is also noted that the CEO may have a reasonable concern about benefits or payments made relating to professional services provided by individual practitioners or by particular kinds of practitioners, as well as relating to the provision of services to which specific items or groups of items relate (**note** to **proposed subsection 129AAD(1)**). According to the Government, by way of explanation:

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42. *Privacy Act 1988* sections 6 and 95A, Schedule 3. For further information about NPPs, see Office of the Privacy Commissioner, *Private sector information sheet 1A – National Privacy Principles*, viewed 28 September 2009, http://privacy.gov.au/materials/types/infosheets/view/6583

43. Explanatory Memorandum, op. cit., p. 5.

> the use of a particular Medicare Benefits Schedule item may have grown so significantly or unexpectedly that the CEO can have a reasonable concern about the provision of any service associated with that item number. The CEO may also have a concern about a professional service if it has been provided by a person who is a particular type of practitioner and the CEO has a concern about that specific group of practitioners.[44]

As **proposed subsection 129AAD(1)** does not specify the type of documents to be provided in response to a notice, it would be up to individual practitioners to decide what documents they have that could substantiate the particular service. According to the Government:

> … Medicare Australia is working with relevant stakeholders, including the Australian Medical Association, to develop guidelines for practitioners on the kinds of information that will substantiate particular services or groups of services. These guidelines will emphasise that clinical information is not to be provided unless it is absolutely necessary to substantiate the service.[45]

Under **proposed subsection 129AAE(1)**, failure to comply with such notice to produce documents would result in civil penalties being imposed. The penalty for individuals would be 20 penalty units or $2200 and the penalty for bodies corporate would be 100 penalty units or $11 000.[46] However, under **proposed subsection 129AAE(2)**, it would be a defence if the defendant could prove that failure to comply was attributed to something over which he or she had no control and against which he or she could not reasonably be expected to guard.

Proposed section 129AAF relates to self incrimination. Whereas the person would not be excused from producing documents subject to a notice under **proposed section 129AAD** on the grounds that doing so would incriminate him or her or expose him or her to a penalty, it is also proposed that documents produced and information obtained as a consequence of producing the documents would be inadmissible as evidence against the person in other criminal proceedings (other than for certain offences relating to false or misleading information or documents), as well as civil proceedings (other than those arising under Part VIA of the Act - 'Civil Penalties').

Proposed section 129AAG sets out what MA may do with documents, extracts or copies produced under notice, in substantiating Medicare benefits or payments made. This includes inspecting documents, extracts or copies; making copies of or taking extracts from a document, extract or copy; or retaining the document, extract or copy for such reasonable time as the CEO or MA employee thinks fit.

It is noted that the Government assures that:

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44. Ibid., p. 1.
45. Ibid., pp. 1-2.
46. A penalty unit is $110 and a body corporate may be charged up to five times the maximum amount charged to an individual for the same offence: *Crimes Act 1914* subsections 4AA(1) and 4B(3).

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> Documents produced under section 129AAD will be viewed by a limited number of specially trained and authorised staff; including medical practitioners employed by Medicare Australia who will be available to receive documents contain clinical details. These authorised staff will be located in National and State or Territory offices. Medicare Australia already has a conflict of interest policy that prohibits staff from being involved in compliance activities when they are acquainted with an individual connected to the audit. Information will be stored in accordance with relevant legislation, current policies and Government requirements that safeguard personal information including the *Privacy Guidelines for the Medicare Benefits and Pharmaceutical Benefits Programs* issued by the Privacy Commissioner under section 135AA of the National Health Act. Those safeguards prevent and detect unauthorised access and cover all facets of personnel security, physical security and IT security.[47]

Proposed sections 129AAH and **129AAI** relates to notices of decision given by the CEO where either no amounts are recoverable as payments or benefits were substantiated and where amounts are recoverable.

Under **proposed section 129AAH**, the CEO must give a notice of any decision made to the relevant person that the documents produced under **proposed section 129AAD** do substantiate the Medicare payment or benefit originally paid.

Notices of the CEO's decision must also be given where:

- the CEO is satisfied for the purposes of **proposed subsections 129AC(1B)** or **(1D)** of the Act that circumstances beyond a person's control exist, and
- the CEO is satisfied for the purposes of **proposed subsection 129AC(1F)** of the Act that circumstances beyond the control of both the person from whom the amount concerned is recoverable and the recipient of the notice exist.

Where amounts are recoverable, under subsection 129AC(1), **proposed subsections 129AC(1A), 129AC(1C) or 129AC(1E)** from a person or that person's estate, the CEO must give written notice to the person or the estate of:

- the decision to claim the amount as a debt
- the reasons for that decision, and
- the person or estate's right to seek an internal review of that decision under **proposed subsection 129AAJ(1)**.

Under **proposed subsection 128AAI(4)**, the CEO cannot serve a notice claiming the debt until after at least 28 days have passed since the notice of the decision had been given to the person or estate, which means that the person or estate has 28 days in which to apply for an internal review of that decision.

47. Explanatory Memorandum, op. cit., p. 11.

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While it is noted that **proposed subsection 129AAI(3)** provides that the validity of such decision is not affected if the person is not advised in writing of that decision, it is noted that the CEO cannot serve the notice claiming the debt until the person is advised that the CEO intends to claim an amount as a debt (see **proposed subsection 128AAI(4)** above).

Proposed section 129AAJ provides for internal review of decisions to claim amounts as debts. The CEO must give written notice of the decision on review within 28 days of receiving the application for review.

According to the Government:

> In practice the power to make decisions under the provisions in this Bill will be delegated to senior officers within Medicare Australia. This means that the internal review powers under section 129AAJ will be exercised by the CEO or a delegate who will be a senior officer of Medicare Australia who is not involved in the compliance audit activity.[48]It is noted that a decision to claim an amount as a debt under this proposed section may only be reviewed once.

The Bill does not provide for further avenues of merits review of such decisions proposed by the Bill and the Explanatory Memorandum is silent as to why this is so. In addition, it is noted that while the Act itself does provide for merits review of other decisions made under the Act, such review is limited to the types of decisions specified in the legislation and would not extend to decisions proposed in the Bill. [49]

Item 4 of the Bill proposes to **insert new subsections 129AC(1A)–(1H)** into the Act. Section 129AC relates to the recovery of amounts paid because of false statements.

Proposed subsection 129AC(1A) provides that if a person must comply with the notice to produce documents in respect of a professional service under **proposed section 129AAD** and fails to do so within the specified timeframe and if that person does not satisfy the CEO that his or her non-compliance is due to circumstances outside of his or her control, the amount of Medicare benefit or payment made in respect of that professional service is recoverable as a debt due to the Commonwealth from the person or that person's estate. This is irrespective of whether the amount had been paid to the person. In other words:

> For example, if a person receives a notice to produce under new section 129AAD and the notice specifies 20 services, but the person only provides documents in relation to 12 services, then the Medicare benefit amount which has been paid in relation to the remaining 8 services becomes a debt which is recoverable from the person or their estate.[50]

48. Ibid., p. 12.
49. See, for example, *Health Insurance Act 1973* sections 3AAB, 19CA, 23DO and 23DZD, 23DZZE.
50. Explanatory Memorandum, op. cit.

Proposed subsections 129AC(1C)–129AC(1F) provide for a situation where following compliance with the notice to produce documents in respect of a professional service under **proposed section 129AAD**:

- the information contained in what was produced does not fully substantiate the amount of Medicare benefit or payment made in respect of that professional service, and
- the person from whom the amount is recoverable does not satisfy the CEO that the reason the information does not substantiate the amount is due to circumstances outside of his or her control or the control of the notice recipient (as the case may be).

In those circumstances, the amount of Medicare benefit or payment made in respect of the professional service in question is recoverable as a debt due to the Commonwealth from the person who provided the professional service or on whose behalf such service was provided; or that person's estate, to the extent that it was not substantiated. This is irrespective of whether the amount had been paid to the person.

Proposed subsection 129AC(1G) provides that where a person is given a notice of his or her liability to pay an administrative penalty under **proposed section 129AEC** and fails to do so within the specified timeframe, the amount set out in that notice is recoverable as a debt due to the Commonwealth from the person or that person's estate.

Importantly, under **subsection 129AC(1H)**, amounts paid as Medicare benefits or payments can only be recovered once.

Items 5–6 propose consequential amendments to subsection 129AC(2) of the Act in relation to interest on amounts recoverable under **proposed subsections 129AC(1A)**, **(1C)**, **(1E)** and **(1G)**.

Item 7 proposes to **substitute subsection 129AC(4)** in the Act so that where an amount is recoverable from a person under subsection 129AC(1); or **proposed subsections 129AC(1A)**, **(1C)**, **(1E)** or **(1G)**; and an amount of Medicare benefit or payment subsequently becomes payable to that person, the CEO may set off all or part of the recoverable amount against all or part of the subsequent amount payable, with the person's agreement.

Item 9 proposes to **insert new sections 129AEA–129AEC** into the Act in relation to liability, amount and notice of the administrative penalty.

Proposed section 129AEA in general, provides for an administrative penalty to be payable in circumstances when a person, who has provided a professional service or who has had a professional service provided on his or her behalf, has a total amount recoverable under subsection 129AC(1); as well as **proposed subsections 129AC(1A)**, **(1C)** and **(1E)**, amounting to more than $2500 or a higher amount where prescribed by regulations.

According to the Government:

> An analysis of Medicare Australia data indicates that this threshold reflects the point at which mistaken claims may become routine, or reflective of poor administration or decision making. In

2008-09, only 22% of practitioners who were found to have made incorrect claims were asked to make repayments of more than $2,500.[51]

Proposed section 129AEB provides for how to calculate administrative penalties. Base administrative penalties may be decreased or increased, depending on the person's conduct with respect to the compliance audit process.

The base penalty amount is 20 percent of recoverable amounts under **proposed paragraphs 129AEA(1)(b)**, **129AEA(2)(e)** and **129AEA(3)(e)**. The base penalty amount may be reduced by 25–100 percent depending on when the person concerned informs Medicare that he or she has been paid too much and whether that person does so voluntarily.[52] The base penalty amount may also be increased according to the person's degree of non-compliance with notices to produce documents, any previous history of owing recoverable amounts over the preceding two year period and where the total sum of recoverable amounts and base penalty amounts is either $30 000 or a higher amount as prescribed in the regulations.[53]

Under **proposed section 129AEC**, the CEO must give a person liable to an administrative penalty written notice of particular information relating to that penalty, such as:

- the professional service to which each penalty relates
- for more than one professional service—the total of administrative penalties, and
- the day when payment of the penalty is due (at least 14 days after the notice is given).

The notice may also deal with a debt arising under section 129AC in relation to the professional service.

Concluding comments

The proposed amendments to the *Health Insurance Act 1973* outlined in the Bill will enable Medicare Australia to enforce compliance to co-operate with notices to produce documents during the compliance audit process, in an attempt to substantiate Medicare benefits and payments made where Medicare Australia is concerned about overpayment.

51. Ibid., p. 2.
52. For further details of how the base amount may be reduced, see ibid., p. 16.
53. For further details of how the base amount may be increased, see ibid., pp. 16–17.

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