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

The *Health Insurance Amendment (Safety Net) Bill 2015* (the Bill) will replace the Original Medicare Safety Net, the Greatest Permissible Gap, and the Extended Medicare Safety Net (EMSN), with a new single Medicare safety net.

While the AMA supports simplification of the Medicare safety net arrangements, it does not support the new Medicare Safety Net contained in the Bill because it reduces the financial assistance provided to patients for out-of-hospital medical care.

The reality is that Medicare rebates do not cover the cost of most doctors' practices. Successive governments have failed to index the Medicare schedule fees in line with other indices such as CPI and average weekly earnings, let alone the increase in the cost of delivering medical care. With year upon year of indexation that has been well below par, and now the Medicare indexation freeze, there is quite a disconnect between Medicare schedule fees and the realistic cost of providing the services.

For private in-hospital services the health insurers have for the most part picked up the difference on behalf of their members. In the out-of-hospital setting this responsibility falls to the Government.

When this responsibility became obvious as out-of-pocket costs grew, Governments were faced with two options to respond:

1. revise the Medicare schedule fees; or
2. introduce a limited safety net that shared the additional costs of out-of-pocket costs between patients and government.

Successive governments responded, at various times, by introducing the three safety nets that are in place today.

These safety nets cover out-of-hospital treatments that are not widely available in the public sector, and which are not privately insurable. Therefore, they cover the services for which much of the package of care is provided outside, rather than inside hospital, which is the nature of the care needed by patients undergoing these treatments. Radiation oncology, psychiatry and IVF are the three most obvious examples of care provided in the community, and for which Medicare is the only available financial assistance for patients who need those treatments.

The Explanatory Memorandum for the Bill states that expenditure under the Medicare safety nets continues to increase significantly. That is not unexpected given Medicare rebates have failed to keep pace with the increased costs of providing medical care, and have been frozen since 1 November 2012 and won't be indexed again until 1 July 2018.

As there is no public information on the actual expenditure on safety net benefits, or the clinical services that the benefits predominantly support, it is not possible for the AMA to assess the extent to which they support out-of-hospital patient care now, and the true impact that the Bill will have on patients. Individual medical practices know their own fees structures and know the impact that the Bill will have on their patients.

However, we can use a standard general practitioner consultation billed at $67.02[1] to illustrate the impact of the Bill, using the structure provided on page 5 of the explanatory memorandum for the Bill:

Extended Medicare Safety Net (Current Law)	New Medicare Safety Net (the Bill)
A patient is charged $67.02 for an item 23. The MBS fee for the item is $37.05 and the out-of-hospital Medicare rebate is $37.05. The patient's out-of-pocket costs are $67.02 - $37.05 =$29.97. 80 per cent of the out-of-pocket costs = $23.98. The limit (EMSN cap) of EMSN benefits for this item is 300 percent of the MBS fee = $111.15. The amount of EMSN benefits payable is $23.98, the lower amount of the 80 per cent of out-of-pocket costs and the EMSN cap. The patient out-of-pocket cost is $6.	A patient is charged $67.02 for an item 23. The MBS fee for the item is $37.05 and the out-of-hospital Medicare rebate is $37.05. The patient's out-of-pocket costs are $67.02 - $37.05 =$29.97. 80 per cent of the out-of-pocket costs = $23.98. The maximum safety net amount is (150% x $37.05) - $37.05 = $18.53. Therefore the amount of the new medicare safety net benefit payable is $18.53, the lower amount of 80 per cent of the out-of-pocket costs and the maximum safety net amount. The patient out-of-pocket cost is $11.44.

To maintain the current financial assistance being provided to patients who have reached the safety net thresholds, the Bill would need to be amended to increase the ***safety-net cap percentage*** in clause 10R of the Bill to 200%.

As a similar impact would apply to the amount of out-of-pocket costs that can accumulate towards the new safety net thresholds, the Bill would need to be amended to increase the ***threshold percentage*** in clause 10P of the Bill to 200%.

A 200% cap would address the inflationary impact of the safety net arrangements, while still providing patients with a safety net to protect them from unexpected medical expenses for out-of-hospital care.

[1] Calculated from average fees charged data provide to the AMA by the Department of Health, assuming 20% of services are patient billed.

The Explanatory Memorandum also states that expenditure continues to be directed in areas where doctors charge the highest fees. The AMA recognises the necessity of the measures taken by the previous Government to cap safety net benefits to moderate excessive fees charged by a few people. However, patients who are unable to afford an out-of-pocket cost for a service in the first place, won't benefit from the safety nets. Medical practices use a mix of billing so that patient billed services offset bulk billing for vulnerable people. As Medicare data is based on the postcode of the patient, it may not accurately show the cross subsidisation that practices apply to ensure vulnerable patients have access to affordable care.

Further, no information has been provided that demonstrates how the safety nets currently support patients who need to access private medical care outside of hospital, where the providers' fees are commensurate with meeting the costs of providing the service.

Without transparency of this data, patients are being asked to accept that they won't be worse off as a result of this Bill, and medical practices will be left to explain to their patients why their out-of-pocket costs have increased.

It is stated that the financial impact of the Bill is a saving of $266.7 million over five years. However, when the caps on EMSN benefits for 74 items were introduced in 2010, $226.8 million of the projected four years savings of $257.9 million were recouped in the first year of the measure.

Given the new Medicare Safety Net caps accumulation amounts and benefits at 150% of the MBS fee less the rebate amount, for all MBS services, the AMA is concerned that the savings are significantly understated.

Illness does not discriminate between the rich, the poor, the young, the aged or the frail, or by postcode. The Medicare safety nets ensure that every Australian who experiences high out-of-pocket medical expenses because of high, and often unexpected, medical needs in a given period, is supported financially through these difficult periods. Safety nets ensure that patients can continue to have affordable access to the care they need to recover and restore their normal, productive lives.

It appears unlikely that the proposed Medicare safety net will support these patients in this way.

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