1991

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

SENATE

HEALTH INSURANCE AMENDMENT BILL 1991

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Health, Housing and Community Services, the Honourable Brian Howe MP)

THIS MEMORANDUM TAKES ACCOUNT OF AMENDMENTS MADE BY THE HOUSE OF REPRESENTATIVES TO THE BILL AS INTRODUCED

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HEALTH INSURANCE AMENDMENT BILL 1991

GENERAL OUTLINE

The purpose of this Bill is to amend the Health Insurance Act 1973 in order to:

(a) reduce the level of medicare benefits for general practitioner services identified in the medical services table (prescribed GP services) for patients other than concessional beneficiaries or, in defined cases, their dependants, by an amount of $3.50 from 1 December 1991 and $5.00 from 1 November 1992 and provide indexing arrangements for this reduction,

(b) enable general practitioners to charge up to a maximum of $2.50 for prescribed GP services where a patient assigns the right to the payment of the medicare benefit to the practitioner and provide indexing arrangements for this charge,

(c) facilitate the commencement of the reduction in level of medicare benefits for prescribed GP services and the introduction of charges for bulk billed services from 1 December 1991,

(d) introduce arrangements for the payment of an indexed $1.00 additional fee to general practitioners for prescribed GP services provided to persons other than concessional beneficiaries who are bulk billed,

(e) ensure that the patient contribution, as defined in the Amendment Bill, to the cost of a single professional service does not exceed the greatest permissible gap, which will initially be $26.80,

(f) introduce new safety-net arrangements for families and individuals, incorporating a voluntary system of family registration, changing the accounting year for the safety-net to a calendar year from a financial year and providing for the issue of safety-net concession cards,

(g) provide for the review by the General Manager of the Health Insurance Commission and the Administrative Appeals Tribunal of decisions made in respect of the refusal to issue additional or replacement safety-net concession cards and the withdrawal and cancellation of these cards,

(h) provide for the indexation of the amount of reduced medicare benefit for prescribed GP services, the maximum co-payment amount and additional amounts payable to a bulk-billing practitioner from 1 November 1993, for indexation of the greatest permissible gap from 1 November 1992 and indexation of the family and individual safety-nets from 1 January 1993; and

(i) include transitional arrangements for various purposes. These arrangements ensure that the existing entitlements of individuals in respect to the safety-net provisions for the 1990-91 financial year are retained notwithstanding the retrospective introduction of a calendar year safety-net.

FINANCIAL IMPACT STATEMENT

The net reduction in medicare benefits expenditure from the reduced benefits for general practitioner out-of-hospital services provided to non-concessionary beneficiaries and from the improved safety-net arrangements is expected to be $111 million in 1991-92 and $267 million in 1992-93.

Administrative costs to the Health Insurance Commission will be affected by the implementation of the new benefits arrangements, the revised safety-net provisions, reductions in the volume of claims processed, and other measures announced in the 1991 Budget. It is estimated that taken together these will result in additional expenditure of $0.70 million in 1991-92 and savings of $7.15 million in 1992-93.

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Notes on Clauses

Clause 1 - Short title, etc.

This is a formal provision specifying the short title of the Act as the Health Insurance Amendment Act 1991 and identifying the Health Insurance Act 1973 as the Principal Act.

Clause 2 - Commencement

Subclause 2(1) provides that clauses 1 and 2 of the Act will commence on the day on which the Act receives Royal Assent.

Subclause 2(2) specifies that all other provisions commence on 1 December 1991.

Clause 3 - Interpretation

This clause amends section 8 of the Principal Act by inserting new subsection 8(1A) which inserts definitions for the purposes of Part II of the Principal Act, including the following:

- 'concessional beneficiary' is based on the existing definition used for the purposes of the safety-net provisions of the Pharmaceutical Benefits Scheme with some differences in respect of persons eligible for treatment under the Veterans' Entitlements Act 1986. The definition includes social security pensioners, persons in receipt of social security benefits and family allowance supplement, persons who have received social security pensions or veterans pensions in the past but no longer qualify under the Social Security Act 1991 or Veterans Entitlements Act 1986 because of their deposits or 'approved investments' (also defined in subsection 10(5)), specified persons eligible for pensions or treatment under the Veterans' Entitlements Act 1986, disadvantaged persons under the Health Insurance Act 1973 and pensioners under the National Health Act 1953.

- 'dependant' in relation to a concessional beneficiary refers to the spouse, child or full-time student child (in specified circumstances) of a 'concessional beneficiary' except for those persons who are concessional beneficiaries only by virtue of being eligible for medical treatment under the Veterans' Entitlements Act 1986. In respect of disadvantaged persons, the meaning of 'dependant' is expanded by reference to the definition of 'dependant' in section 3 of the Principal Act.

- 'maximum co-payment amount' means an amount of $2.50.

- 'patient contribution' identifies 3 separate situations:
  (1) where a person has been billed by a doctor under section 20 of the Principal Act and is entitled to receive a medicare benefit in respect of that medical expense;
  (2) where a benefit is assigned for prescribed GP services under subsection 20A and a practitioner is entitled to charge up to the maximum co-payment amount;
  (3) any other case.
  In the first situation the patient contribution is the difference between the Schedule fee (or the medical expenses where they are less than the Schedule fee) and the amount of benefit payable apart from the safety-net provisions. In the second situation the patient contribution is the maximum co-payment amount. In the third situation the patient contribution is nil.

- 'prescribed GP service' is a prescribed professional service specified in one of the identified groups of services in the general medical services table.

- 'safety-net amount' means $246.

Clause 4 - Entitlement to medicare benefit

This clause amends section 10 of the Principal Act by omitting subsections (2) to (6) and replacing them with new subsections.

New subsection 10(2) defines a benefit payable in respect of a service as one of three alternatives, either:

(a) an amount equal to 75% of the Schedule fee for those services, not excluded under the regulations, which are provided in a hospital or day hospital as referred to in paragraph (da) of the definition of 'basic private table' or 'basic table' in subsection 4(1) of the National Health Act 1953 or

(b) an amount equal to 85% of the Schedule fee for services not covered by paragraphs (a) or (c) or

(c) an amount equal to 85% of the Schedule fee, less the specified amount, for prescribed GP services other than those provided to concessional beneficiaries and their dependants, as defined. The specified amount for the year beginning 1 December 1991 is $3.50 and for later years, commencing from 1 November 1992, is $5.00.

New subsection 10(3) continues the existing ceiling on the patient contribution for a particular service covered by paragraphs 10(2)(b) and 10(2)(c) providing that where the difference between the benefit and the Schedule fee is more than the 'greatest permissible gap' the benefit, in these circumstances, is the Schedule fee less the 'greatest permissible gap'. From 1 December 1991 this amount will be $26.80 which is in line with the existing legislation which would have had the effect of indexing the existing amount of $26 to $26.80 from 1 November 1991. Thereafter the greatest permissible gap will continue to be indexed each subsequent 1 November.

Clause 5 - Registration of families, safety-net, safety-net cards, review of decisions, etc.

This clause inserts eleven new sections after section 10 in the Principal Act for the purpose of establishing a safety-net in respect of the amount of patient contributions to family medical expenses and to amend the existing provisions related to the safety-net for individuals.

New subsections 10AA(1) - (2) provide that a family member may apply, at any time, to the General Manager of the Health Insurance Commission for registration of the family. Under this section and subsequent sections, a family may include a spouse and any dependent children (as defined in subsection 10AA(7)).

New subsection 10AA(3) requires applications for registration to list the names of all family members.

New subsections 10AA(4) - (5) make provision for variations of the registration to add or delete family members and new subsection 10AA(6) provides that only a child may be registered as a member of more than one family at the same time.

New section 10AB sets out the consequences of altered family composition.

Subsection 10AB(1) provides that where a person joins a family subsequent to the family's registration and the family's registration is varied by the addition of that person, any medicare claims in the calendar year in which the registration is varied made before the variation may count towards the family's safety-net, but no increased benefits will be paid where a medicare claim has already been made and a benefit paid.

Subsection 10AB(2) provides that where a person ceases to be a family member and the family's registration is varied by the deletion of that person before the family (including that person) reaches the safety-net in respect of the calendar year in which the variation is made, the person may have all claims incurred during that year count towards an individual safety-net or towards another family safety-net where the person becomes a member of another registered family.

Subsection 10AB(3) provides that where a person ceases to be a family member after that family reaches the safety-net during a year and the family's registration is varied by the deletion of that person, the person is treated for the purposes of entitlement to medicare benefit at any time during that year as if he or she had remained a member of that family and cannot be treated as a member of another registered family in respect of that year.

New section 10AC provides for new safety-net arrangements for families.

New subsection 10AC(1) defines 'relevant service' for the purpose of sections 10AC and 10AD to exclude services rendered in hospitals or day hospital facilities; it also defines 'year' to mean the year commencing on 1 January 1992 and thereafter each calendar year.

New subsection 10AC(2) provides that where a person makes a 'threshold claim' for a 'relevant service' rendered to the person or a member of the person's family for which medical expenses were incurred in that year, and the person has made 'prior claims' for benefit for that year before the threshold claim, and the Commission is satisfied -

that the medical expenses of the services which are the subject of 'threshold claim' and the 'prior claims' have been paid, that the sum of patient contributions paid for prior claims is less than the safety-net amount ($246 for the year beginning 1 January 1992), and that the addition of the patient contribution from the threshold claim will cause the safety-net amount to be equalled or exceeded,

the benefit payable for the relevant service is increased by the amount of the patient contribution for the service.

New subsection 10AC(3) makes provision for the treatment of the medical expenses of a child who is a member of two registered families. If the commission is satisfied that the medical expenses of the child have been incurred by an adult belonging to one family the expense will be treated as being incurred by that family; otherwise the Commission will treat the expense as being equally incurred by both families of which the child is a member.

New subsections 10AC(4) - (5) set out the effect of the date when a family registers on the treatment of claims and on inclusion of benefits for the purposes of reaching the safety-net amount. Registration before 1 April 1992 means that retrospective adjustment will be made to benefits paid for services claimed in the three month period from 1 January 1992 to 31 March 1992 if the family has passed the safety-net amount prior to registration. Registration after 31 March 1992 means that benefits paid in a calendar year before registration are included for the purposes of calculating patient contributions incurred in that year but no retrospective adjustment to benefit will be made for claims prior to registration.

New subsection 10AC(6) explains that a person who receives payment of a benefit by cheque for a relevant service is taken to have paid that amount of medical expenses represented by the cheque; the subsection also enables the making of regulations to set down more precisely when medical expenses are incurred for certain services.

New subsection 10AC(7) provides that if a person's right to payment of a benefit is assigned to a practitioner under section 20A the safety-net effect is as if the person claimed a benefit for the service, the claim was accepted by the Commission and the medical expenses for that service were paid.

New section 10AD introduces parallel provisions for a safety-net for individuals to those set out in new section 10AC for a safety-net for families. In essence these provisions differ from those currently applying for individuals only in that the basis of the year for the purposes of the safety-net is changed from a financial year to a calendar year.

New subsection 10AD(2) applies section 10AD to any person who is not a member of a registered family, subject to the operation of new subsection 10AB(3).

New subsection 10AD(3) imposes the same conditions about the increased benefits to be paid to an individual, after the Commission has satisfied itself that the person's claim is a threshold claim and payment of the patient contribution will result in the safety-net amount being equalled or exceeded, as the conditions described in new subsection 10AC(2) for the safety-net for families.

New subsection 10AD(4) provides that a person who receives payment by cheque of a benefit for a relevant service is taken to have paid that amount of medical expenses represented by the cheque; the sub-section also enables the making of regulations to determine when medical expenses are incurred for services.

New sub-section 10AD(5) provides that if a person's right to payment of a benefit is assigned to a practitioner under section 20A the safety-net effect is as if the person claimed a benefit for the service, the claim was accepted by the Commission and the medical expenses for that service were paid.

Section 10AE imposes an obligation on the Commission to confirm the composition of a family for the purpose of determining eligibility for increased benefits under the safety-net arrangement for families.

New subsection 10AE(1) requires the Commission - if it is satisfied that if it were not for section 10AE a registered family would be entitled to increased benefits under section 10AC for a calendar year - to write to the family to ask whether its composition remains as it was when registered under section 10AA, or where a change has been notified to the Commission, as it was when the composition was last notified to the Commission.

New subsection 10AE(2) prevents the payment of increased benefits to family members for the year in respect of which the confirmation of the family composition was sought and the issue of a safety-net concession card to that family for that year until the family provides the information sought by the Commission under subsection 10AE(1).

New section 10AF determines the conditions for a person to be eligible to be issued with a safety-net concession card. The reason for issuing safety-net concession cards is so that a person is able to provide evidence to a doctor that he or she is entitled to increased benefits.

New subsections 10AF(1)-(2) provide that, subject to subsection (6), where the patient contributions of a person, or of all the persons in a registered family, equal or exceed the safety-net amount during the relevant entitlement period (each calendar year) and the Commission has verified that fact, the person is eligible to be issued with a safety-net concession card, and the Commission is required to issue the card to the person in respect of that entitlement period.

New subsections 10AF(3) - (4) require the card to be in a form approved by the General Manager and to include particulars both of the entitlement period to which the card relates and of the person to whom the card is issued or of each person in the family where a person is a member of a registered family.

New subsection 10AF(5) provides that omission from a card of a member of a person's registered family will not affect the validity of the card.

New subsection 10AF(6) provides that a safety-net concession card must not be issued in respect of a previous year. The issue of a card is unnecessary where a person or family reach the safety-net threshold in a given, previous calendar year only by virtue of claims lodged after the end of that previous calendar year for services provided in that previous calendar year, because all services for which a higher benefit is payable would already have been provided.

New section 10AG states that the person to whom a safety-net concession card is issued, and each member of a registered family where a card is issued to a person in a registered family, will be a holder of the card.

New subsection 10AH provides for the issuing of additional cards. New subsections 10AH(1) - (2) allow for the issue of an additional card to a person who is a holder of a card, particularly where the person's card has been lost, stolen or destroyed or where the person's particulars are not on the card.

New subsections 10AH(3) - (4) provide for the issue of a new card to the original card holder where, through a variation of the registration of the original card holder's family, another person becomes registered as a member of the original card holder's family; such a replacement card must include particulars of the holders of the original card and the new family member, each of whom become a replacement card holder after the new card is issued.

New subsection 10AH(5) requires an officer who makes a decision to refuse to issue an additional replacement card under sub-section 10AH(1) or (3), to issue a notice of that decision to the person requesting the card.

New section 10AI gives a person the right to seek review of a decision to refuse to issue an additional or replacement safety-net concession card, and of a decision to issue a notice requiring the return of a card.

New subsection 10AI(1) incorporates by reference the meaning of decision in the Administrative Appeals Tribunal Act 1975.

New subsection 10AI(2) provides that if a decision is taken under subsection 10AH(1) or (3) to refuse to issue an additional or replacement safety-net concession card to a person requesting the card, or if the General Manager issues a notice under subsection 10AK(1) requiring a person to return a safety-net concession card, the person requesting the card or the person receiving the notice may seek reconsideration of the decision.

New subsection 10AI(3) requires a person seeking reconsideration of a decision to apply for review of the decision within 28 days of receipt of the notice issued under subsection 10AH(5) or 10AK(1).

New subsections 10AI(4) -(5) require the General Manager in reconsidering a decision to refuse to issue an additional or replacement safety-net concession card, either to affirm the decision or to issue the card, and in reconsidering a decision to issue a notice requiring the return of a safety-net concession card, either to affirm the decision or to withdraw the notice requiring the return of the card.

New subsections 10AI(6) - (7) require the General Manager in making a reconsidered decision under subsection 10AI(4) - (5) to give a written notice, within 28 days of making the decision to the applicant for the card or to the person to whom the notice to return a card was issued, which contains the decision and the reasons for the decision and states that application for review of the General Manager's decision may be made to the Administrative Appeals Tribunal.

New subsection 10AI(8) provides that any failure to include in a notice issued under subsection 10AI(6) - (7) a statement about the decision being reviewable by the Administrative Appeals Tribunal does not affect the validity of the General Manager's decision.

New subsection 10AI(9) identifies a person whose interests are affected by the General Manager's decision under paragraph 10AI(4)(a) affirming a decision not to issue a card, or under paragraph 10AI(5)(a) affirming a decision to require the return of a card, as the person who may apply to the Administrative Appeals Tribunal for review of the decision.

New subsection 10AI(10) is a delegation power, restricting the General Manager's power to delegate under subsection 10AI(4) or (5) to a person performing the duties of the office of Deputy Manager or Assistant Manager of the Commission.

New section 10AJ provides that where the safety-net concession card is issued for a calendar year its effect commences as from the date of issue and ceases at the end of the calendar year.

New subsection 10AK(1) enables the General Manager to require a holder of a safety-net concession card to return the card to the Commission for cancellation where the card is issued to a person not eligible for the card. New subsection 10AK(2) imposes a penalty on a person who fails without reasonable excuse to comply with a notice issued under subsection (1).

Clause 6 - Indexation

This clause amends section 10A of the Principal Act by substituting a definition of 'year' in subsection 10A(1) for the purposes of indexing the amount specified in new subparagraph 10(2)(c)(ii), the greatest permissible gap, the safety-net amount referred to in new sections 10AC and 10AD, the maximum co-payment amount and the amount of additional fee payable to a bulk billing practitioner under new section 20C.

The clause also substitutes a new subsection 10A(2) to include a new CPI indexation table with indexation days and reference quarters specified separately for the amounts referred to in new subparagraph 10(2)(c)(iii), the greatest permissible gap, the safety-net amounts in new sections 10AC and 10AD, the maximum co-payment amount and the amount of additional fee payable to a bulk billing practitioner under new section 20C.

Clause 6 also substitutes a new definition of 'previous index number' in sub-section 10A(5).

Clause 7 - Assignment of medicare benefit

This clause amends section 20A of the Principal Act by inserting a new sub-section 20A(1A) which allows a bulk billing practitioner to charge persons who have not reached the safety-net level, other than concessional beneficiaries and their dependants, an amount not exceeding the maximum co-payment amount for a prescribed GP service.

Clause 7 also inserts new subsections 20A(1B) to (1E). These provisions assist a practitioner in determining whether a patient is a concessional beneficiary or has reached the safety-net level and insert penalties for falsely demonstrating these matters.

New subsection 20A(1B) provides that a practitioner rendering a prescribed GP service is entitled to be satisfied that a patient is a concessional beneficiary or a concessional beneficiary's dependant if specified evidence is produced or an approved form is signed to the effect that the patient is a concessional beneficiary or concessional beneficiary's dependant. New subsection 20A(1D) is a similar provision in respect of safety-net concession cardholders. A practitioner is entitled to be satisfied that benefit is increased upon production of a current safety-net concession card relating to the patient.

New subsection 20A(1C) makes it an offence for a person to demonstrate that a person is a concessional beneficiary or a concessional beneficary's dependant when that person is not a concessional beneficiary or concessional beneficiary's dependant, and new subsection 20A(1E) creates a similar offence in respect of demonstrating that a person is a safety-net concession cardholder.

There is a consequential amendment to paragraph 20A(1)(b) so that the reference to 'the practitioner accepting the assignment in full payment' is made subject to new subsection 20A(1A).

Clause 8 - Additional fees, benefit adjustments & refund of co-payments

This clause inserts new sections 20C and 20D.

New section 20C provides for a $1.00 additional fee in respect of certain bulk billed services.

New section 20D applies in respect of prescribed GP services the right to benefits for which have been assigned and the claim for benefit submitted to the Commission. It provides for the adjustment of medicare benefit to a practitioner and refund of co-payments where the Commission becomes aware that the patient was a concessional beneficiary or a concessional beneficiary's dependant, or had reached the safety-net level, at the time a service was rendered to a patient and a co-payment was made in respect of the service. This adjustment or refund can be made on written application from the patient, the person who paid the co-payment or the practitioner, or may be done on the Commission's own initiative.

Transitional provisions

Clauses 9 to 14 insert transitional provisions to provide detail on the application of the safety-net entitlements, assignment of medicare benefits, payment of additional fees, adjustment of benefits and refund of co-payments, retrospective payment of benefit increases and payments out of the Consolidated Revenue Fund during the year commencing 1 January 1991.

Clause 9 - Safety-net entitlements

Subclause 9(1) provides that a person's entitlement to increased benefits under subsection 10(3) of the Principal Act in respect of medical expenses incurred before 1 July 1991 will not be affected by the transitional provision.

Subclause 9(2) provides that subsection 10(3) of the Principal Act continues to apply to the transitional year commencing on 1 January 1991, with specified modifications, set out in subclauses 9(3)-(6) and clauses 10, 11 and 12.

These modifications include the following:

- for the purpose of determining whether a person has reached the safety-net level, subclause 9(3) inserts an explanation as to which patient contributions are to be used in computing a person's entitlement to increased benefits under subsection 10(1).

- subsection 10(4A), which excludes 'basic table' professional services from safety-net amount calculations, is given continued operation in respect of the transitional year but subsections 10(5) and (6) do not apply.

- subclause 9(4) provides that where the Commission makes a payment to a practitioner in respect of an assignment under section 20A the medical expenses in respect of that service are treated as being paid for the purpose of subsection 10(3). In this situation the patient contribution for the purpose of subsection 10(3) will be nil.

- subclause 9(5) deems a person receiving a cheque for medicare benefits drawn in a practitioner's name under subsection 20(2) to have paid the medical expenses represented by the cheque and further identifies a professional service for the purpose of applying subsection 10(3).

- definitions of 'medicare benefit', 'relevant amount' and 'Schedule fee' are inserted for the purposes of subsection 10(3) as it applies to the transitional year. Two definitions of 'patient contribution' are also inserted, one is given application in respect of medical expenses incurred before 1 December 1991 and is based on the definition found in subsection 10(6) of the Principal Act and the other is given application in respect of medical expenses incurred on or after 1 December 1991 and is based on the definition found in new subsection 8(1A) in the Amendment Bill.

Clause 10 - Assignment of medicare benefit

This clause provides a transitional provision where medicare benefit has been assigned. This subclause amends subsection 20A(1A) for the period 1 December 1991 to 31 December 1991 allowing a bulk billing practitioner to charge persons who have not reached the safety-net level, other than concessional beneficiaries and their dependants, an amount not exceeding $2.50 for a prescribed GP service. This subclause also provides for the application of subsections 20A(1D) and (1E) for the purpose of the transitional arrangements.

Clause 11 - Additional fees

This clause provides a transitional provision for payment of additional fees in respect of prescribed GP services provided during the period 1 December 1991 to 31 December 1991.

Clause 12 - Adjustment of benefit & refund of co-payment

Clause 12 is a transitional provision allowing the adjustment of benefits and refund of co-payments for prescribed GP services which are rendered during the period 1 December 1991 to 31 December 1991.

Clause 13 - Retrospective payment of benefit increases

Provision is made in clause 13 for the retrospective payment of benefit increases where persons are entitled to increased benefits in respect of the transitional year for claims lodged before 1 December 1991. These claims are to be paid as soon as practicable by the Commission on or after 1 December 1991.

Clause 14 - Payments by the Commonwealth

This clause extends the effect of section 125 of the Principal Act, providing for payments out of the Consolidated Revenue Fund to cover increased medicare benefit payments (including retrospective payments), additional payments under section 20C and refunds under section 20D, as these payments are provided for in the transitional arrangements in clauses 9 to 13.