CHERE
CENTRE FOR HEALTH ECONOMICS RESEARCH AND EVALUATION

An assessment of the new Medicare Safety Net: what can previous experiences tell us?

A submission to the Australian Senate Community Affairs Legislation Committee's Inquiry into the Health Insurance Amendment (Safety Net) Bill 2015

November 2015

UTS
UNIVERSITY OF TECHNOLOGY, SYDNEY

About CHERE

CHERE is an independent research unit affiliated with the University of Technology, Sydney. It has been established since 1991, and in that time has developed a strong reputation for excellence in research and teaching in health economics and public health and for providing timely and high quality policy advice and support. Its research program is policy-relevant and concerned with issues at the forefront of the sub-discipline.

CHERE has extensive experience in evaluating health services and programs, and in assessing the effectiveness of policy initiatives. The Centre provides policy support to all levels of the health care system, through both formal and informal involvement in working parties, committees, and by undertaking commissioned projects. For further details on our work, see www.chere.uts.edu.au.

Author

A/Prof Kees van Gool

Contact details

Centre for Health Economics Research and Evaluation (CHERE)
University of Technology Sydney
Level 2, Building 5D, 1-59 Quay Street,
Haymarket NSW 2000

i: www.chere.uts.edu.au

An assessment of the new Medicare Safety Net: what can previous experiences tell us?

Members of the Centre for Health Economics Research and Evaluation, based at the University of Technology Sydney, conducted two independent reviews of the Extended Medicare Safety Net (EMSN), published in 2009 and 2011. The comments below draw-out the potential impacts of the new Medicare Safety Net, based on the results of our two previous reviews.

Background

One of the fundamental aims of the Australian health care system is to provide universal access to high quality health care to those in need. The architects of Medicare foresaw a system whereby health care should be available to all Australians, without regard to income or any other personal circumstances (Scotton and Deeble, 1968). Making sure that health care is affordable to all members of the community is the key component of this objective.

We've always taken the view that the various Medicare Safety Nets should contribute to, rather than impede, this objective.

A review of the EMSN, conducted in 2009, found that the policy led to number of unintended consequences. First, the distribution of EMSN benefits paid by Government was highly skewed in favour of wealthier sections of the community (van Gool et al 2009). Second, it was inflationary, with evidence of health care providers increasing their fees; particularly among some professional groups practicing in obstetrics and assisted reproductive technologies (ART). These higher fees meant that there was substantial leakage of government spending going towards doctor revenues, rather reducing the out-of-pocket (OOP) costs faced by patients (Savage et al 2009). These unintended consequences meant that government expenditure on the EMSN was growing by around 20% per year; substantially higher than first anticipated (van Gool et al 2011).

Following on from the review, the Australian government announced that it would place limits on the amount of EMSN benefits it would pay for a small number of Medicare items. These items related to obstetric services, pregnancy-related ultrasounds, ART services and a number of individual procedure items. The caps were implemented in January 2010, and their impact was immediate and extensive. The second review, published in 2011, found that Government EMSN expenditure fell by 42% in 2010, compared to 2009 but at the same time OOP costs increased (van Gool et al., 2011).

An assessment of the new Medicare Safety Net arrangements

The remaining part of this statement will examine two key aspects of the Safety Net reforms. First, changes to the thresholds and second the implementation of caps for all Medicare services.

A. Changes to Safety Net thresholds

Under the new arrangements, there will be:

- Three thresholds, instead of two.
- Reduced thresholds dollar amounts for general and concession card holders, a small increase for recipients of Family Tax Benefit Part A.
- Broadening of the definition of what constitutes a family for the purposes of the EMSN.
- Singles qualify for a lower threshold.
- Limits on the amount of OOP costs that contribute to the annual threshold. Before all OOP costs for eligible services would contribute to the threshold count. Under the new arrangements the amount is restricted to 1.5 times the MBS Schedule Fee.

<u>Potential impact:</u>

There are two countervailing effects of the threshold changes. On the one hand, the lowering of the thresholds, having lower thresholds for singles as well as more generous rules around defining a family will lead to more people qualifying. On the other hand, the limitations on the amount of OOP costs that can contribute to the threshold will make it harder to qualify. The Department

estimates that as a result of the changes, there will be more people qualifying for Safety Net Benefits, although I don't think it is clear how many more.

The big question is whether the reforms will lead to a change in the type of people who qualify for Safety Net benefits? The answer depends on how many concession card families experience annual OOP costs between $400 and $638; and general families with annual OOP costs between $1000 and $2000 – because these are the people who stand to benefit under the new arrangements. If there are more people in the former than the latter, I would expect that the change in thresholds will lead to a more progressive distribution of Safety Net Benefits. It should be noted that concession card status is a poor proxy of household income. There are many poor households who do not have a concession card; and many wealthy families who do.

Capping the amount of OOP costs that can contribute to the Safety Net threshold will have further implications on how many and what type of families qualify for benefits. To some extent, this part of the reform will disadvantage those who seek services where the doctor's fees are substantially above the MBS Schedule Fee, but should have less impact on those who see doctors who charge within 150% of the MBS Schedule Fee. This change may invoke a number of changes on behalf of doctors and patients, seeking to derive maximum benefits from the Safety Net.

- Create greater incentives for patients to seek out doctors who charge fees within 150% of the MBS Schedule Fee. This, in turn, may invoke some more price competition among doctors.
- Doctors to redistribute their fees across items, so that their fees across an episode of care are better aligned to the inherent incentives of the policy.
- Increase the volume of services provided.

B. Caps on Safety Net Benefits

This change will place a cap on the amount of Safety Net Benefits paid for all Medicare items. The cap will be equal to 150% of the MBS Schedule Fee.

Potential impact

We can look to some guidance from the impact of the EMSN caps implemented in 2010. The review, published in 2011, found strong evidence of doctor fee reductions for some of the capped items, particularly among those doctors who were charging very high fees. For ART services it was difficult to establish a clear assessment of the impact of caps because there were significant other reforms in this clinical area that were implemented at the same time. For obstetrics, there was some evidence that doctor fees fell throughout the year, particularly among those obstetricians with very high fees. In both ART services and obstetrics there were signs of anticipatory behaviours just prior to 2010 that made it difficult to establish a clear assessment of the impact of caps.

Even with these qualifications, there are clear signs that the introduction of caps did put downward pressure on the fees charged by doctors, particularly among those who charged very high fees. However, the caps introduced in 2010 and subsequent years, were highly targeted at MBS items where excessive fees are being charged and where there has been excessive growth in EMSN benefits, and where there is a risk that practitioners could shift excessive fees onto other items. Hence, placing caps on all MBS items may not have as big an impact as the caps placed on the selected items. This may help explain why the Department is expecting only very modest savings of $267 million over five years, compared to the fall in EMSN benefits of $230 million in the year after the introduction of caps in 2010. Nevertheless, there may still be some downward pressure on fees – particularly on providers who provide an episode of care that comprises multiple items; for example, radiation oncology and psychiatry.

Besides fees, the introduction of caps also had a number of other effects. We found evidence of providers changing their fee structures by reducing fees for capped items but increasing them for uncapped items. The review found evidence of this among providers of plastic and reconstructive surgery. The review also found evidence of an increase in doctor fees for uncapped items that were complementary to capped items. As the out-of-hospital fees for the

capped cataract surgery items were falling, the provider fees for anaesthesia for lens surgery increased substantially. The shift in billing practices between capped and uncapped items should no longer occur under the reforms.

One final impact of the caps was that in some specialist fields there was evidence of additional fee growth for in-patient services but a reduction in fees for out-of-hospital services. This type of response remains a possibility under the new caps. Whilst this is more likely to take place in episodes of care where a patient typically has part of their care provided in the out-of-hospital sector and part of it in the in-hospital sector, the potential to shift practice (or billing) between the out-of-hospital and in-hospital sectors remains a possibility.

One further potential consequence of the reforms is that provider groups who charge items that attract extensive EMSN benefits will become more concerned about the level of the MBS Fee. For many items on the MBS, the Schedule Fee is well below the fees charged by many providers. With the caps placed on all items, this may lead to further pressure on the government to increase the Schedule Fee. This may occur, for example, through the listing of new items through the Medical Services Advisory Committee.

Summary

Although many uncertainties remain on the potential implications of the Safety Net changes, based on my assessment I believe that the reforms are a step in the right direction, when compared to current EMSN arrangements. This is because the new Safety Net will:

- No longer reward highly excessive fees.
- Simplify how the caps are set.
- Lower the threshold for concession cardholders, which is likely to benefit those on lower incomes as well as singles.

However:

- For these reforms to be more effective we need greater transparency on fees.

- The new Safety Net does not address the big challenge in the Australian health care system which is to align health care needs with health care access. The EMSN may even have reinforced existing patterns of specialist care funded under Medicare that are highly skewed towards the wealthy. It is unlikely that new Medicare Safety Net will address this problem either. This is still a major challenge for reform.
- Many key aspects of the reform remain uncertain – therefore a further review would be highly informative for future policy development.

References

Deeble, J., & Scotton, R. (1968). Compulsory health insurance for Australia. Aust Econ Rev, 4, 9-16.

Savage, E.J., Van Gool, K., Haas, M.R., Viney, R.C. & Vu, A. 2009, Extended Medicare Safety Net review report 2009 : a report by CHERE prepared for the Australian Government Department of Health & Ageing, Department of Health & Ageing, Canberra, pp. 1-80

Van Gool, K., Savage, E., Viney, R., Haas, M., & Anderson, R. (2009). Who's getting caught? An analysis of the Australian Medicare Safety Net. Australian Economic Review, 42(2), 143-154.

Van Gool, K., Savage, E.J., Johar, M., Knox, S, Jones, G., &, Viney, R.C. 2011, Review of Extended Medicare Safety Net Capping Arrangements Report: a report by CHERE prepared for the Australian Government Department of Health & Ageing, Department of Health & Ageing, Canberra