Australian Government

Department of Health and Ageing

Submission to the Senate Standing Committee on Community Affairs for the Inquiry into the *Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009*

Contents **Page**

Summary

When the Extended Medicare Safety Net (EMSN) was introduced in 2004, the then Minister for Health and Ageing stated that the purpose of the program was "protect all Australians from high out-of-pocket expenses"[1]. The independent review of the EMSN, conducted by CHERE found that the EMSN did assist patients with very high out-of-pocket costs (in excess of $2,000), cancer patients and has also made Assisted Reproductive Technology (ART) services more affordable.

However, the EMSN Review report also found that the program has led to fee inflation in some areas. This was a concern that was also raised by the Senate Select Committee on Medicare that examined the conception of a government funded safety net to assist people with costs for out-of-hospital services in 2003. CHERE found that since the introduction of the EMSN in 2004, average fees charged increased by 4.2 per cent per annum (excluding pathology and general practitioner services) over and above inflation. CHERE estimated that 70 per cent of this increase was a direct result of the EMSN[2].

This means that some patients that do not qualify for EMSN benefits are now being charged higher average fees. The majority of the population does not receive a benefit from the EMSN. In 2007, around 8.5 per cent of families received an EMSN benefit, and less than one per cent of single people received an EMSN benefit[3]. Even more alarming, is the fact that out-of-pocket costs for some Medicare services have now increased to the level seen before the introduction of the EMSN, and in some cases, patients are now experiencing higher out-of-pocket costs.

Medicare data shows that despite increased government expenditure, a patient that is charged at the average fee for services such as hair transplantation (item 45560) and one type of varicose vein treatment (item 32500), out-of-pocket expenses have increased since the introduction of the EMSN, even when EMSN benefits are taken into account. For example, for item 32500 (the one type of varicose vein treatment that will have an EMSN benefit cap) the average fee has increased by approximately 116 per cent (not adjusted for inflation) from 2003 to 2008. This means that those patients that do not qualify for the EMSN, are now faced with much higher out-of-pocket costs for this service, and those patients that do receive additional EMSN benefits for their service, are still, on average, facing higher out-of-pocket costs[4].

The EMSN Review report noted that despite increasing Government expenditure on the EMSN, in some circumstances the program is having a "negligible impact on average out-of-pocket costs per service" and that the extent of the fee increase has led to "considerable leakage of government benefits towards providers' incomes, rather than reduced costs for patients". The EMSN Review report found that for every dollar spent in 2008, " providers received 43 cents and 57 cents went towards reducing patient out-of-

[1] Hansard. House of Representatives. 4 December 2003. Second Reading for the *Health Legislation Amendment (Medicare) Bill 2004*
[2] CHERE. 2009. Extended Medicare Safety Net (EMSN) Review Report 2009. pg vi.
[3] CHERE. 2009. EMSN Review Report 2009. pg. 24.
[4] Medicare data based on date of processing. Figures have not been indexed by inflation unlike the methodology used by EMSN Review Report. For more information about varicose vein treatment, refer to section 12.

pockets", however for some items this ratio was as high as 78 cents going to the provider, with only 22 cents going to the patient[5].

The introduction of the EMSN fundamentally changed the Medicare arrangements by removing the limit on the Government contribution for Medicare services by covering 80 per cent of the out-of-pocket cost (once the patient reaches the threshold) regardless of the fee charged by the doctor. CHERE identified that "for services where an episode of care is likely to make patients qualify for EMSN benefits, providers feel fewer competitive market pressures to contain their fees"[6].

Expenditure on the EMSN is increasing significantly. In some areas such as obstetrics, the growth in expenditure is not proportional to the increase in the number of services provided. Between 2007 and 2008, total expenditure on the EMSN increased from $319 million to $414 million[7]. This growth is unsustainable. EMSN benefits paid for obstetrics and ART services, including In-vitro Fertilisation (IVF) accounted for more than 50 per cent of this expenditure.

Some ART stakeholders have argued that the increased cost of technology and quality assurance compliance for ART practices in recent years has impacted on the fees charged and the rate of growth in the fees charged. This does not account for the fee increases seen most recently, and why the extent of fee inflation has not been demonstrated in other specialty areas with high technology costs, such as radiation oncology. There have also been increases in the average MBS Schedule fees for ART of 4.25 per cent per annum since 2000. This is comprised of general fee increases for the MBS items, a shift in the billing profile of ART practitioners towards charging the higher priced services and the increases in MBS funding for new procedures, such as intracytoplasmic sperm injection (ICSI) in May 2007. Therefore the increase in MBS rebates is higher than the standard indexation applied to MBS items on 1 November each year. In contrast, the average total MBS rebate (including EMSN benefits) per ART cycle has increased by 30 per cent per annum since the introduction of the EMSN.

The *Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009* (the Bill) will allow the Minister for Health and Ageing to determine the maximum benefit payable under the EMSN (the EMSN benefit cap) for selected MBS items. The levels of the EMSN benefit caps will be set out in delegated legislation[8]. This Bill will enable the Minister to place a limit on the Government contribution for selected services that the EMSN Review report identified as having large increases in fees charged or services where the majority of the EMSN benefit is going to funding higher fees rather than reducing patient costs.

Extensive details about the operation of the caps have been available on the MBS Online website since the Budget announcement and have also been included in this submission to assist members of the Committee, medical practitioners and the general public.

At the Senate hearing of 14 July 2009, representatives of the Australian Medical Association (AMA), the National Association of Specialist Obstetricians and Gynaecologists (NASOG) and the IVF Directors Group expressed concerns that under the changes ART patients

[5] CHERE. 2009. EMSN Review Report 2009. pg. 77.
[6] CHERE. 2009. EMSN Review Report 2009. pg. 76.
[7] Medicare data (date of processing).
[8] The MBS items and the levels of the EMSN benefit caps are set out at Appendix A

charged at the current average fees of about $5,500 to $6,000 will experience an increase in their out-of-pocket costs from $1,000 to $3,000. This is not correct. Section 8 and Appendix F of this submission demonstrates the impact of the EMSN caps on these patients.

There were many inaccuracies provided by some witnesses before the Committee relating to the mechanisms for qualifying for EMSN, patients' out-of-pocket costs, the reasons for EMSN caps on services that are usually provided in-hospital and business inputs. These are addressed in this submission.

1. Introduction

On 16 June 2009, the *Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009* was referred by the Senate Selection of Bills Committee to the Senate Standing Committee on Community Affairs for inquiry and report into:

"the changes relating to obstetrics, cataract surgery and IVF amongst other matters"[9].

This submission provides further information about these matters, and those issues raised by the Senate Committee at the hearings and should be read in conjunction with the:

- *Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009* (Attachment A);
- Explanatory Memorandum for this Bill (Attachment B); and
- Extended Medicare Safety Net Review Report 2009 (Attachment C).

2. The current context - Medicare Benefits Schedule and the Original Medicare Safety Net

2.1 The Medicare Benefits Schedule

The Medicare program provides access to hospital and medical services for eligible Australian residents and certain categories of visitors to Australia. The elements of Medicare include free treatment for public patients in public hospitals and subsidised private treatment, including visits to general practitioners (GPs) and optometrists. The Australian Government subsidises private treatment through the payment of rebates or benefits for medical, optometric and certain allied health services listed in the Medicare Benefits Schedule (MBS)[10].

The MBS sets out the MBS Schedule Fee (MBS fee) and the Medicare rebates for approximately 5,700 services. The MBS coverage for medical services and the MBS fees are reviewed by the Department in consultation with the medical profession, having regard to the time involved in performing the services and the complexity and professional difficulty involved. In most cases, MBS fees are indexed every year on 1 November.

For services provided by GPs to non-referred, non-admitted patients the Medicare rebate is 100 per cent of the MBS Schedule Fee. A rebate of 100 per cent is also paid for services provided by practice nurses or Aboriginal Health Workers on the behalf of a GP. For all other services provided out-of-hospital, to non admitted patients, the Medicare rebate is 85 per cent of the MBS fee[11]. GPs are eligible for additional payments when they bulk bill Commonwealth concession cardholders and children under 16 years of age. From 1 November 2009, new bulk billing incentives will be introduced for diagnostic imaging services and pathology episodes.

For treatment in a private hospital, patients receive a Medicare benefit of 75 per cent of the Medicare fee. If the patient also holds Private Health Insurance (PHI), their PHI fund will

[9] Selection of Bills Committee. Report No 8 of 2009.
[10] The Medicare item descriptors and the MBS fees and rebates for each MBS items is available at www.mbsonline.gov.au
[11] There is a cap on the maximum amount between the 85 per cent and 100 per cent of the MBS fee for out-of-hospital services. As at January 2009, this maximum cap was equal to $68.10.

cover the remaining 25 per cent of the MBS fee. If their doctor chooses to charge above the Medicare fee there is a 'gap' that the patient may be required to pay. Some private health insurers have arrangements in place which may cover some or all of the doctors' fees for hospital treatment. These are known as gap cover arrangements. Unless a patient's private health insurer has a gap cover arrangement in place with their doctor which will cover all of the doctor's charge, the patient may have to contribute towards the gap out of their own pocket.

Section 51 (xxiiiA)[12] of the Constitution of the Commonwealth of Australia states that the Parliament will have the power to make laws for

> "The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances".

This has been interpreted to mean that although the Government can make law regarding the payment of benefits for medical and dental services; it has no authority to control the amount doctors charge for their services as this would amount to civil conscription. Doctors are free to determine their own value of the health service they provide. While this means that doctors are under no obligation to charge the MBS fee set by the Government, they may alter their fees for particular individuals if they choose to.

2.2 Payment of Medicare benefits

The conditions for payment of Medicare benefits are set out in the *Health Insurance Act 1973* (the HIA). Section 20 of the HIA provides that Medicare benefits are payable to the person who has incurred the medical expense, that is, the patient or the person paying the bill on their behalf. The Medicare benefit is a patient benefit, not a payment to the doctor. There is one exception to this principle. Section 20A of the HIA provides that where the doctor has agreed to accept the Medicare benefit as the total payment for the Medicare service, then the patient can assign their benefit to the doctor and Medicare will make the payment directly to the doctor. This arrangement is commonly referred to as bulk billing.

Where a patient is bulk billed for a service, the practitioner has agreed to accept the Medicare rebate as the total payment for the service. It is not permitted under the HIA (paragraph 20A(1)(b)) for practitioners to charge any additional fees such as a 'facility fee' relating to the Medicare service where they bulk bill.

2.3 Billing for Medicare services

Under the HIA and the *Health Insurance (General Medical Services Table) Regulations* a medical practitioner should only bill for a service that they have themselves provided and services that have been provided on their behalf by non-medical professionals, for example by practice nurses or Aboriginal Health Workers[13]. An example of a by and on behalf of service, is some of the services provided by an embryologist, e.g. fertilisation of an egg, in a ART cycle, which is billed to the patient by the doctor.

[12] Commonwealth of Australia Constitution Act.

[13] There are some exceptions allowed under the HIA. E.g. pathology practices often bill under the one provider, even though the services are being provided by multiple medical practitioners.

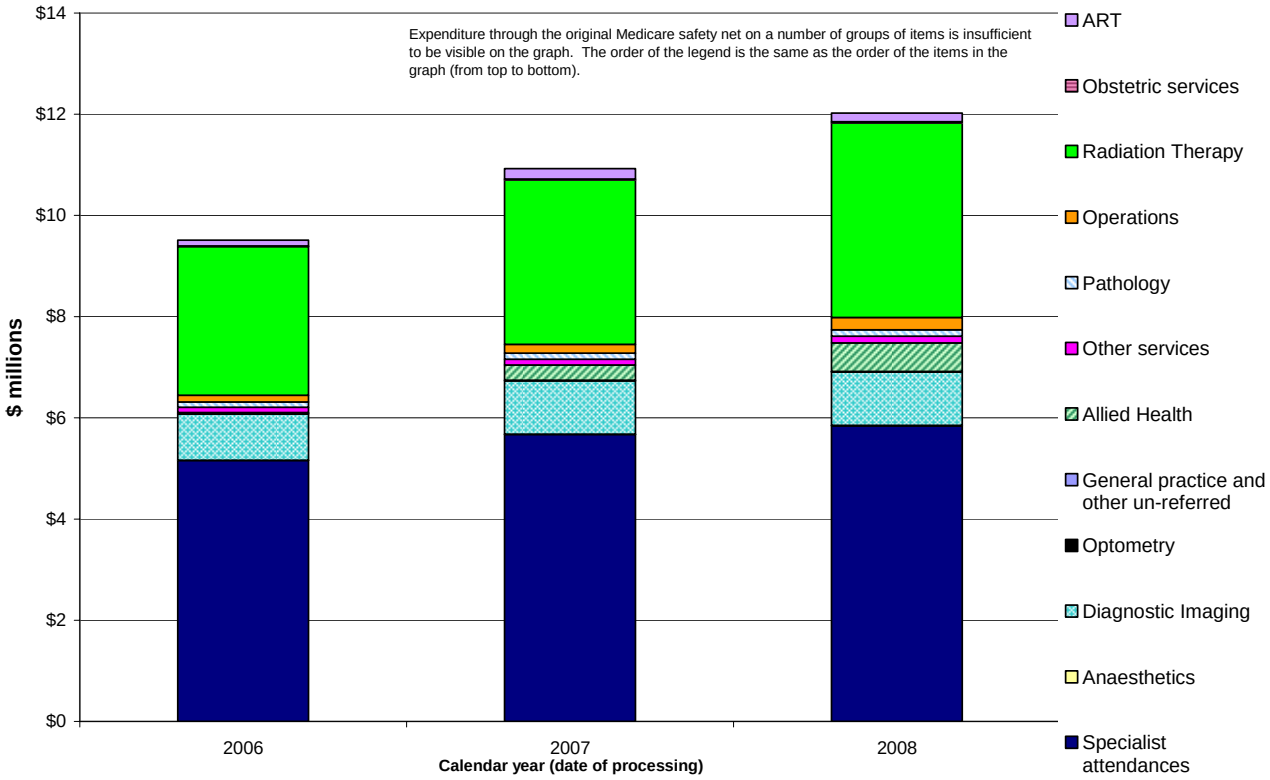
'Figure-head' or 'headline' billing, where one doctor's provider number is being used to bill patients for the services provided by other medical practitioners, as alleged by some witnesses in an attempt to explain the large amount of Medicare benefits being paid to some practitioners, is only permitted in certain circumstances (not including ART specialists) and would be an issue for Medicare Australia to investigate.

2.4 Original Medicare safety net

The EMSN operates in conjunction with the original Medicare safety net, which is also commonly referred to as the 'gap' safety net. The original Medicare safety net covers the difference between the Medicare benefits paid and the Medicare schedule fee for out-of-hospital services. Once the 'gaps' (the difference between the MBS fees and the benefit) accumulate to a threshold of $383.90, Medicare benefits then increase to 100 per cent of the schedule fee for the remainder of the calendar year for out-of-hospital services, up from the standard Medicare benefit of 85 per cent of the schedule fee. Where the original Medicare safety net threshold of $383.90 is reached before the relevant EMSN threshold, a patient receives 100 per cent of the schedule fee and any remaining out-of-pocket expenses continue to accumulate towards the EMSN threshold relevant to the patient's circumstances.

Even though the threshold amount is lower than the EMSN threshold amounts, as the amount of expense that accumulates towards the original safety net threshold is limited, it is possible for a patient to qualify for the EMSN before they qualify to benefit from the original safety net.

Figure 2.1 – Expenditure under the Original Medicare Safety Net by calendar year ($ millions)



3. The Extended Medicare Safety Net

3.1 Introduction of the safety net

The concept of an additional Medicare safety net for out-of-hospital services has been examined twice by the Senate Select Committee on Medicare. The program conception of the safety net that was first put forward in the then Government's *A Fairer Medicare* package was different to the EMSN that was implemented in 2004. Many of the changes were due to recommendations put forward by the Senate, as a result of the two Senate select reports into Medicare *(Medicare – healthcare or welfare?* and *Medicare Plus: the future for Medicare?)*.

The initial proposal was for a new Government funded safety net only for Commonwealth Concession Card holders. The Committee recommended that the safety net policies be rejected in their current form. The policy was adjusted to be applied to all Medicare-eligible people. The later proposal included two thresholds $500 and $1000, with the lower threshold for Commonwealth Concession Card holders and families receiving Family Tax Benefit Part A (FTB (A)). The Committee recommended against implementation of the proposal in that form.

The Senate Select Committee argued that the two thresholds were "too high to deliver meaningful benefits to any more than a tiny handful of Australian families and individuals each year". The EMSN that was enacted in legislation reduced the thresholds to $300 and $700, but still retained the structure of two levels of threshold amounts[14].

There were common concerns raised in both of the Senate reports. These included that many health care costs would not be eligible for the safety net, and therefore people would still have high out-of-pocket medical expenses. In addition, it was highlighted that the safety net could result in an inflationary effect on doctors' fees, as the doctors who charge over the threshold amounts would know that patients would be covered for 80 per cent of the costs, and may therefore charge higher fees.

3.2 The Extended Medicare Safety Net

The Extended Medicare Safety Net (EMSN) was introduced in 2004 through the *Health Insurance Amendment (Medicare) Act 2004*. This Act amended the HIA to include new sections 10ACA and 10ADA to provide for the conditions for eligibility for the EMSN and the calculations for the payment of EMSN benefits for families and individuals.

The EMSN provides an additional rebate for Australian families and singles who have out-of-pocket costs for Medicare eligible out-of-hospital services once an annual threshold in out-of-pocket costs has been met. Out-of-pocket costs are the difference between the doctor's charge and the standard Medicare rebate. Out-of-hospital services include GP and specialist attendances and services provided to non-admitted patients in private clinics.

Once the relevant annual threshold has been met, Medicare will pay for 80 per cent of any future out-of-pocket costs for Medicare eligible out-of-hospital services for the remainder of that calendar year. The out-of-pocket costs for family members accumulate towards the one threshold, meaning that family members help each other to reach the out-of-pocket threshold.

There are two threshold amounts for the EMSN, the general threshold and the lower threshold. In 2009, the annual lower threshold for Commonwealth concession cardholders and people who receive Family Tax Benefits (Part A) is $555.70. For all other singles and families the annual general threshold is $1,111.60. (Note that the EMSN thresholds were increased to $500 for concession card holders and FTB (A) recipients and $1,000 for all others in the 2005-06 Budget as a way to address the higher than anticipated expenditure through the program).

The EMSN operates on a calendar year basis. All out-of-pocket thresholds are reset to zero on 1 January each year and singles and families will have to reach the out-of-pocket threshold again to receive EMSN benefits for that calendar year. The threshold amounts are indexed by Consumer Price Index (CPI) on 1 January each year as set out in Section 10A of the HIA. Further information about the operation and the eligibility requirements for the lower threshold is available in the EMSN Review report (Attachment C). Table 3.1 shows the number of people that have received an EMSN benefit by calendar year.

Table 3.1 – Approximate Number of EMSN Recipients[15]

Year	Lower Threshold	General Threshold
2005	824,000	338,000
2006	443,000	232,000
2007	502,000	288,000

[15] CHERE. EMSN Review Report 2009. pg 9.

Figure 3.1 Distributions of EMSN Benefits by age and sex for 2007-08 [16]

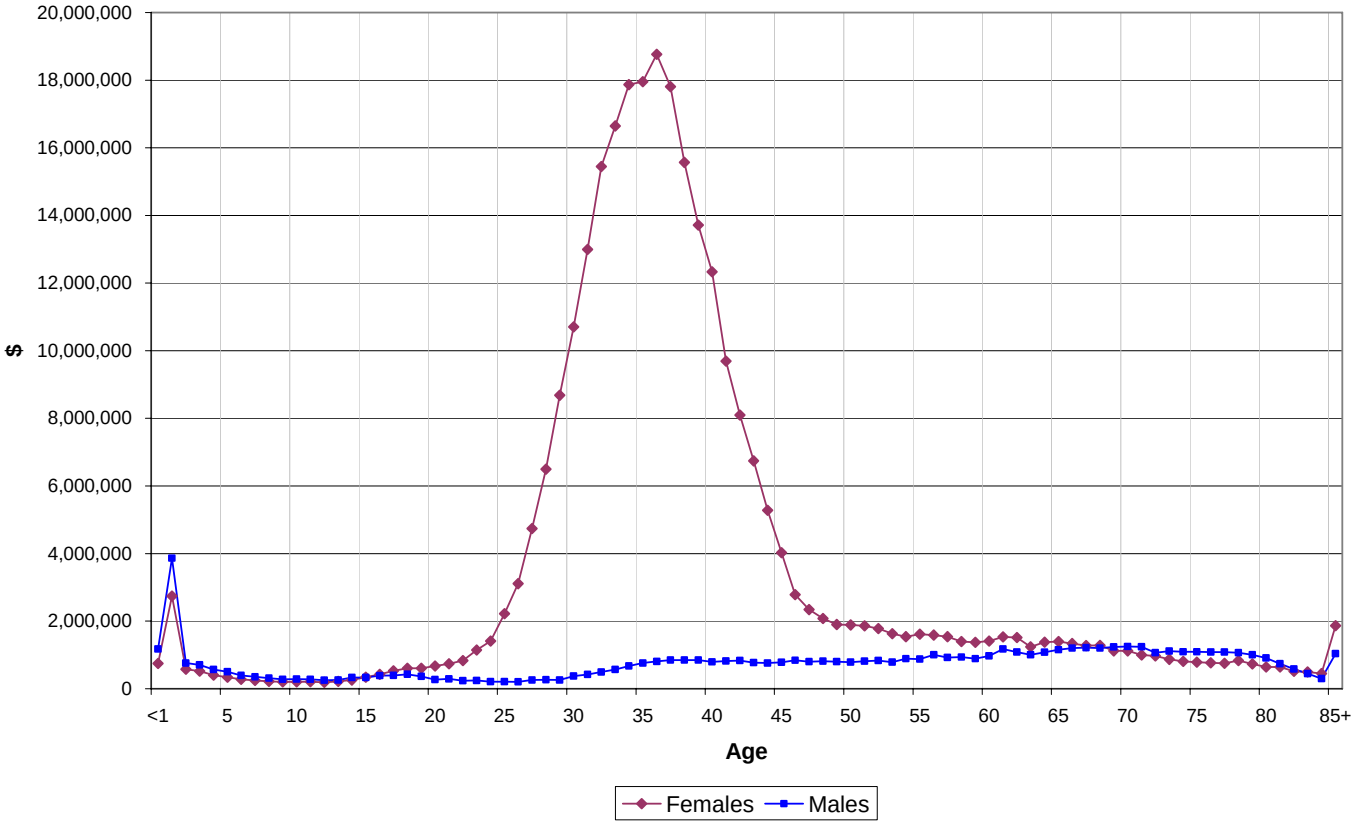


Figure 3.1 shows that the majority of EMSN benefit goes to female patients of child bearing age.

3.3 Expenditure under the EMSN

The MBS is funded from a special appropriation and expenditure on the program is demand driven. Expenditure on the EMSN represents a relatively small proportion of total MBS expenditure, approximately 3.0 per cent in 2008[17].

Expenditure under the EMSN is rapidly increasing. Between 2007 and 2008 expenditure increased by 30 per cent to $414 million[18]. Expenditure increased across many areas of the MBS, including allied health services, but the most significant increase was for ART services ($70.5 million to $102.1 million).

Table 3.2 shows EMSN benefits paid by broad type of service group for calendar year 2008. This table shows that while GP services account for 44 per cent of total out-of-hospital services and 33 per cent of total MBS benefits paid, less than 8 per cent of EMSN expenditure is paid for these services. This partly reflects the high rates of bulk billing. In contrast, while obstetrics services only accounts for 0.5 per cent of out-of-hospital services and around 2 per cent of total expenditure through the MBS, it accounts for around 30 per

[16] Medicare data (date of processing)
[17] Medicare data (date of processing)
[18] Medicare date (date of processing)

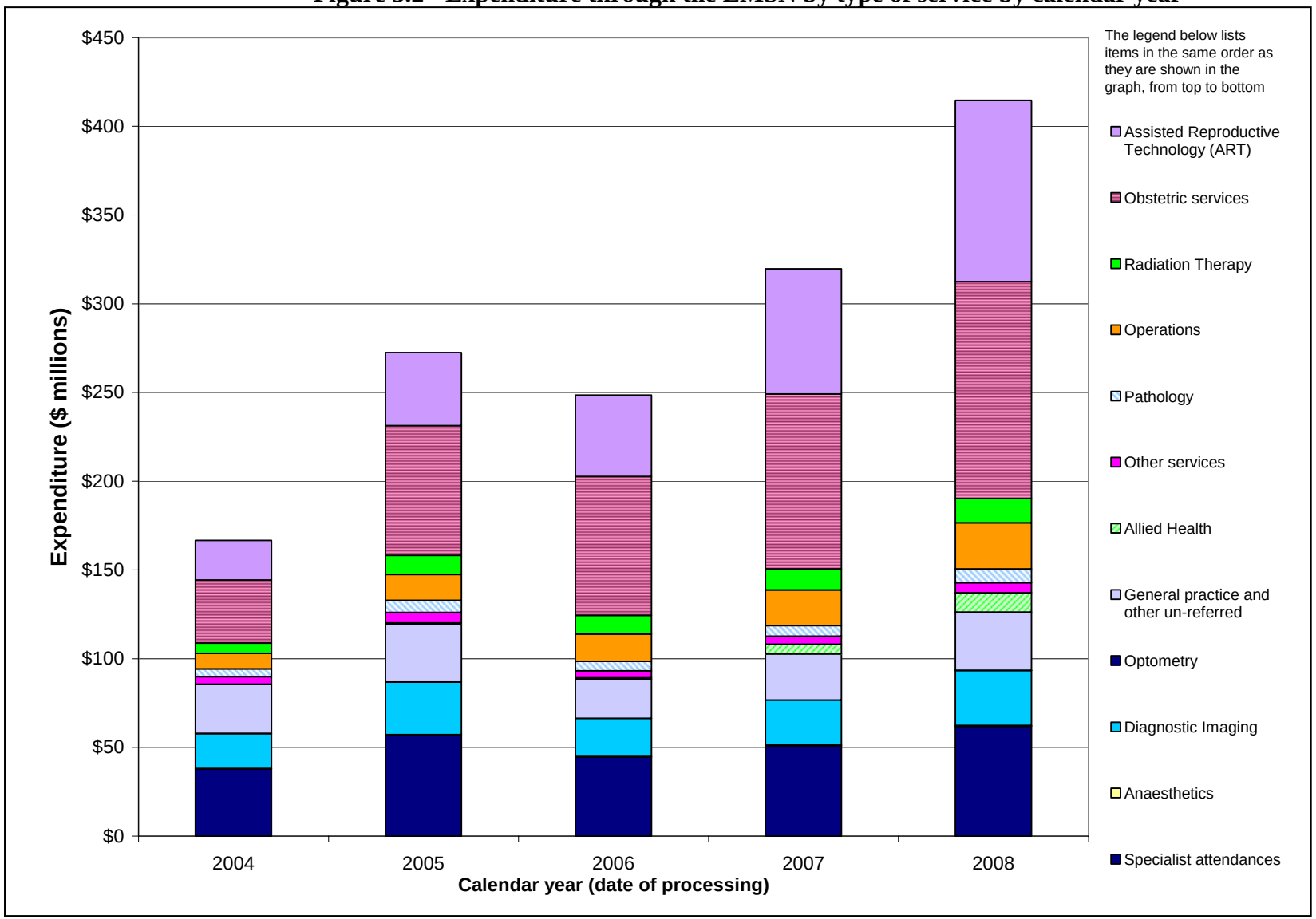
cent of EMSN expenditure. The purpose of the EMSN was to help patients with high out-of-pocket costs, particularly patients with cancer, however Table 3.2 shows that only 3.3 per cent of EMSN benefits are paid for radiation therapy, whereas more than 50 per cent of EMSN benefits are paid for obstetrics and ART services.

Table 3.2 - Proportion of out-of-hospital services (OOH) and EMSN benefit by broad type of service for calendar year 2008*

	Number of OOH Services	Proportion of total OOH services	EMSN Benefits	Percentage of Total EMSN benefits	Total MBS expenditure	Proportion of Total MBS benefits
	million		**$ million**		**$ million**	
Total	**263.0**		**414.1**		**13,695.3**	
GP & non-referred attendances	115.7	44.0%	32.8	7.9%	4,574.4	33.4%
Allied Health	5.4	2.1%	10.8	2.6%	534.0	3.9%
Specialist Attendances	17.6	6.7%	61.8	14.9%	1,484.4	10.8%
Obstetrics	1.4	0.5%	122.3	29.5%	227.9	1.7%
Anaesthetics	0.1	0.1%	0.6	0.1%	295.4	2.2%
Pathology	89.0	33.8%	7.1	1.7%	1,929.1	14.1%
Diagnostic Imaging	15.7	6.0%	31.0	7.5%	1,888.0	13.8%
Operations	5.0	1.9%	25.9	6.3%	1,163.5	8.5%
Assistance at Operations	0.0	0.0%	0.1	0.0%	51.9	0.4%
Optometry	5.9	2.2%	0.1	0.0%	265.4	1.9%
Radiation Therapy	1.0	0.4%	13.7	3.3%	167.8	1.2%
ART services	0.2	0.1%	102.1	24.7%	202.2	1.5%
Other	5.7	2.2%	5.8	1.4%	911.4	6.7%

*includes Medicare benefits paid for in-hospital and out-of-hospital services. Date of processing

Figure 3.2 - Expenditure through the EMSN by type of service by calendar year



Note: Expenditure decreased in 2006 due to the increase in the thresholds.

3.4 Growth in fees charged across different specialty groups

As set out in Section 4, there are significant differences in the rate of increase in the fees charged by professional group and for different types of services.

Figure 3.3 illustrates the relative increases in the average MBS fee charged between 2000 and 2009 for different groups of services. In order to allow a comparison between the groups of services, the average fees charged are standardised against an index of 1.0 for the average fees charged in the first three months of the 2000 calendar year.

Under this methodology, a score of 2.0 means that the average fee charged for that group of services has doubled since the first quarter of 2000. An increase in the average fees charged for a group of services could be caused by a number of reasons including increases in the cost of providing the services, a shift towards the use of higher cost services or the introduction of newer, higher cost, technology.

Shown in Figure 3.3 is that the average fee charged for obstetrics services has significantly more than trebled since 2000. Though the large increase in 2004 could reflect the introduction of the EMSN and the funding through the MBS of the 'booking fee', the obstetrics profession has not provided any rationale for the ongoing high rate of increases in the average fees charged.

For ART, the increase in the average fee charged is more modest, increasing by a factor of 2.7 (170 per cent) between 2000 and 2009. However, to put this into context, the average fee charged for radiotherapy treatment has increased to a factor of 1.7 (70 per cent). Radiation oncology is similar to ART in that they are both predominantly provided on an out-of-hospital basis and require the employment of a large number of staff. It is difficult to see that the cost or complexity of delivering ART services has increased by so much more than radiotherapy (increasing to a factor of 1.7, or 70 per cent), diagnostic imaging (increasing by 30 per cent), or pathology (6 per cent).

The EMSN Review report found that there was no increase in the average fees charged as a result of the EMSN for GP attendances, specialist attendances, pathology as a broad group of services or diagnostic imaging as a broad group of services.

Although the average fees charged for radiation oncology services did increase after the introduction of the EMSN, the EMSN Review report found that the increase was due to an increase in the Medicare benefits rather than the EMSN itself. That is, the increase in average fees charged were a result of increases in the level of MBS Schedule fees, rather than the introduction of the EMSN.

Figure 3.3 – Index of the average increase in MBS fees charged by service groups for years 2000 to 2009 (date of processing)

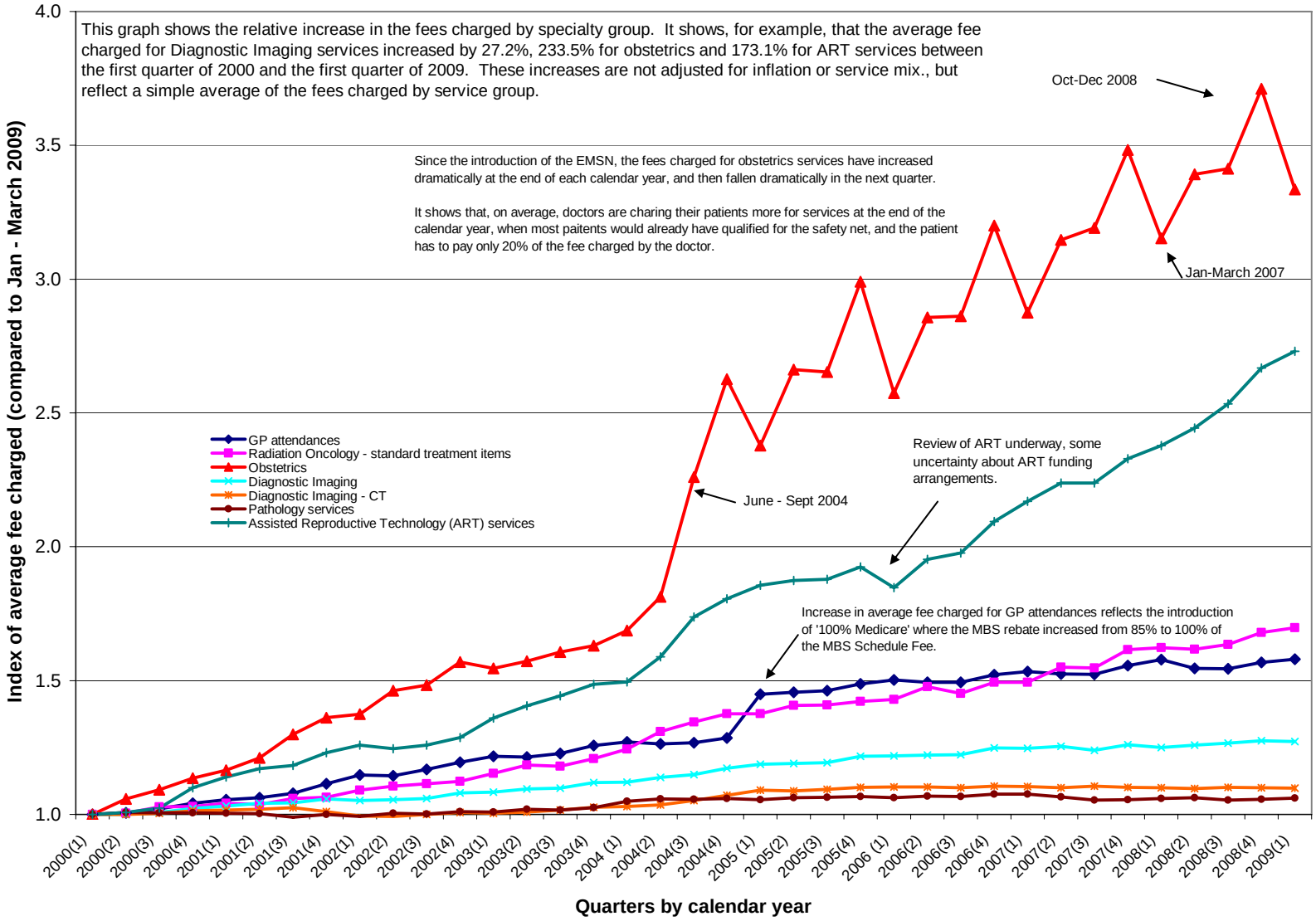


Figure 3.4 seeks to take into account general changes in the service mix for ART by including the change in the average MBS Schedule fee, and comparing that to changes in the average fee charged. The average MBS Schedule fee for ART has increased by standard MBS indexation and more than CPI since 2000 with a move towards providing higher cost services and the introduction of MBS item 13251 for intracytoplasmic sperm injection (ICSI) in May 2007. The average fee charged for ART services increased by 173 per cent over the period, or 19 per cent per annum.

Between the first quarter of 2007 and 2008, the average fee charged for ART services increased by 10 per cent. It then increased another 15 per cent over the next year to the first quarter of 2009. Increases of this magnitude are not apparent in other areas of the MBS.

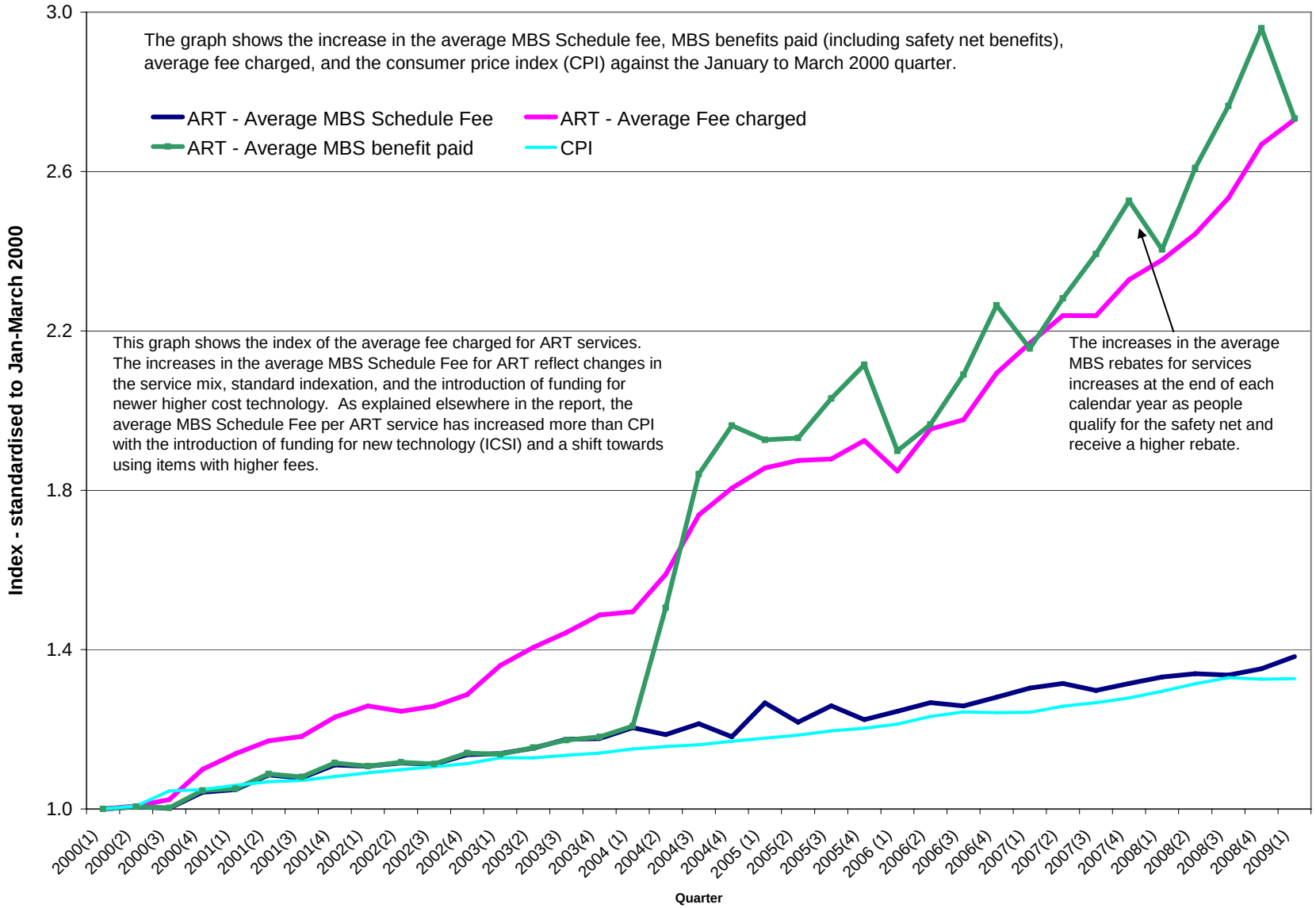
One explanation that has been put forward to explain this change is that a 'booking fee' for ART services used to be in place prior to the introduction of the EMSN and part of the reasons for the increase is the inclusion of this fee into the fees charged through Medicare. However, as set out in section 8.6, there has been an MBS funded item for the planning and management of an ART cycle since 1990 and in any case it is insufficient explanation for ongoing significant increases in the fees charged five years after the EMSN was introduced.

There are many services associated with ART treatment that are not subsidised by Medicare. These include:[19]

- Embryo storage $300 per annum
- Blastocyst culture $600
- Assisted hatching $260
- Pre-implantation Genetic Diagnosis $600
- Donor sperm, donor eggs and embryos $100
- Non PBS subsidised drugs $300
- Theatre Fee $450
- Accommodation Fee $260

[19] Estimated costs are derived from available public information and are indicative only.

Figure 3.4 Changes in the average ART MBS Schedule Fees, MBS Benefits Paid, and fees charged from 2000 to 2008



4. The Extended Medicare Safety Net Review Report 2009

The concerns of the Senate Select Committee on Medicare led to a Senate amendment to the *Health Legislation Amendment (Medicare) Act 2004*, that is, the inclusion of an independent review of the operation of the Act in relation to the EMSN. The review was included as a measure to address the doubts about the future effectiveness of the EMSN and to ensure that a detailed analysis of the program would occur which would be made available to the public.

Section 4 of the *Health Legislation Amendment (Medicare) Act 2004*[20] states:

"1. The Minister must initiate, by the third anniversary of the day of which this Act commences, a review of the operation, effectiveness and implications of this Act.
2. In selecting a person to conduct the review requirement by this section, the Minister must seek and select a person from nominations received from independent academic institutions.
3. The Minister must cause to be tabled in both Houses of the Parliament a copy of the report of the review within 15 sitting days of receiving the report."

The review of the EMSN was initiated on 15 March 2007 by the former Minister for Health and Ageing. The Centre for Health Economics Research and Evaluation (CHERE), University of Technology, Sydney was engaged for the project in late 2008 following an open tender process. The *Extended Medicare Safety Net Review Report 2009* was tabled in both Houses of Parliament on 12 May 2009.

In its submission and evidence to the Senate Inquiry, the AMA raised some concerns about the methodology of the EMSN Review report. Further information has been provided at Appendix C which addresses these concerns.

[20] *Health Legislation Amendment (Medicare) Act 2004*. accessed at http://www.comlaw.gov.au/ComLaw/Legislation/Act1.nsf/asmade/bytitle/912F8F3BDEE2A2ECCA256F720010F29D?OpenDocument

Box 4.1 - Key Findings of the EMSN Review Report

- Around 50 per cent of all EMSN benefits in 2007 was attributed to obstetrics and ART services.
- EMSN benefits have more than doubled for both these groups since 2004.
- The majority of EMSN benefits are distributed to the wealthier sections of the community.
- Nine per cent of families and less than 1 per cent of singles received EMSN benefits in 2007.
- That the EMSN is responsible for increases in fees charged overall, however, it has not caused an increase in the average fee charged for GP attendances, specialist consultations, pathology or diagnostic imaging services.
- In 2007, for every dollar spent on the EMSN, 43 cents went to providers as a result of higher fees charged and 57 cents went towards reducing patient out-of-pocket costs.
- For a group of items with high out-of-pocket costs, the amount going to providers was as high as 78 cents for some services, including some ART services, and procedures to treat varicose veins (item 32500) and vision impairments (items 42702 and 42740). See Appendix B for a full list of items.
- Providers who generally charge high out-of-pocket costs per service, experience less market competition on fees, as they are aware their patients are likely to qualify for EMSN benefits.
- The structure of the EMSN has lead to significant increases in provider fees for some services, as the EMSN provides benefits that increase with provider fees regardless of how high those fees are.
- The additional Government spending on EMSN benefits has not been matched by a reduction in patient out-of-pocket costs.

5. The Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009

5.1 Purpose of the Bill

The *Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009* (the Bill) amends the *Health Insurance Act 1973* (the HIA) to allow the Minister for Health and Ageing to determine, by legislative instrument, the amount of the maximum increase in the Medicare benefit (commonly referred to as the EMSN benefit) for specified MBS items. The maximum increase in the benefit will be known as the EMSN benefit cap.

A new section 10B gives the Minister for Health and Ageing, the authority to determine which MBS items will have an EMSN benefit cap and the level of the EMSN benefit cap to apply to those items. The MBS items and the EMSN benefit caps will be set out in a legislative instrument. The draft *Health Insurance Amendment (Extended Medicare Safety Net) Determination 2009* was tabled with the Bill to demonstrate the operation of section 10B.

New subsections 10ACA(7A) and 10ADA(8A) are required to specify that where an MBS item is determined to have a EMSN benefit cap under section 10B, then the benefit payable under the EMSN is not to exceed the EMSN benefit cap.

New subsections 10ACA(7B) and subsections 10ADA(8B) are technical amendments required to determine which EMSN benefit cap will apply in situations where two or more pathology services are treated as a single service. This rule is commonly known as episode coning.

5.2 Health Insurance Extended Medicare Safety Net Determination 2009

The *Health Insurance Extended Medicare Safety Net Determination 2009* (the Determination) will be made under the authority of new section 10B and will set out the MBS items which will have an EMSN benefit cap applied and the dollar amount of the EMSN benefit cap. A draft of the Determination was tabled in the House of Representatives on 28 May 2009 and in the Senate on 16 June 2009. The Determination was provided in a draft format to provide Parliament with the full picture on how the policy of capping EMSN benefits will operate and to be open and transparent about the levels of the caps applying to each of the selected MBS items.

It is necessary for the levels of the EMSN benefit caps to be set out in a Determination. This will allow the Government to be responsive to changes in circumstances which impact on the EMSN. It also means that small administrative changes that occur frequently, such as renumbering of MBS items and machinery of Government changes and annual indexation of EMSN benefit caps by CPI, can occur without adding to the legislative program of Parliament. There will be a number of changes to the draft Determination in the lead up to the implementation of the 2009-10 Budget measures, including the restructure of ART services and the introduction of a small number of additional Medicare items for obstetrics. Both of these changes will require changes to the Determination.

Concerns raised by stakeholders that the Minister can unilaterally impose caps on other MBS items without consultation or reference to Parliament are unfounded.

The Determination will be a legislative instrument within the meaning prescribed by the *Legislative Instruments Act 2003* (LIA Act). No exemptions from disallowance or tabling in Parliament have been sought. This means that the instrument will be tabled in Parliament each time it is changed or remade, and Members of Parliament will have the opportunity to examine the instrument. This also means that the Minister is accountable to Parliament for any changes to the capping of EMSN benefits policy.

The AMA has recommended that the Bill be amended to include the provision that the Minister should consult with the medical profession prior to the introduction of the EMSN benefit caps. It should be noted that section 17 of the LIA Act sets out that before a rule-maker makes a legislative instrument, and particularly where the proposed instrument is likely to have a substantial impact on business or competition that appropriate consultation has taken place.

The LIA Act also requires that the explanatory statement to the instrument includes a description of the consultation undertaken, or an explanation as to why no consultation has occurred.

6. The Policy of Capping Extended Medicare Safety Net Benefits

The introduction of the EMSN in 2004 fundamentally changed Medicare arrangements. Prior to the EMSN there was a limit or a cap on the maximum Government benefit payable for every Medicare service - that is the Medicare Schedule Fee. This limit meant that patients were more sensitive to increases in medical fees as they were required to meet the total additional cost out of their own pockets[21].

When the EMSN was introduced, the limit on the Government contribution per service was removed. Once the patient reaches the applicable threshold they receive 80 per cent of their out-of-pocket cost for that service, regardless of the fee charged by the doctor. Under the current structure of the EMSN, once the patient has reached the threshold, for every $100 that the doctor increases their fee, the patient is only required to pay $20. The EMSN Review report provided evidence that some doctors have been using the structure of the EMSN to increase their fees[22]. Capping EMSN benefits for selected items directly responds to those areas identified by the EMSN Review report.

6.1 2009-10 Budget announcement

As part of the 2009-10 Federal Budget, the Government announced that it would be placing a maximum limit or EMSN benefit cap on a selected number of MBS items[23]. The MBS items that will have an EMSN benefit cap under these measures are:

- All obstetrics services;
- Some pregnancy related ultrasounds;
- All ART services;
- One type of varicose vein surgery (MBS item 32500);
- One type of cataract surgery (MBS item 42702);
- Injection of a therapeutic substance into an eye (MBS item 42740); and
- Hair transplantation for the treatment of hair loss as the result of disease or injury (MBS item 45560).

The EMSN benefit caps (excluding indexation) for each of the selected items is detailed at Appendix A. The EMSN benefit caps will be indexed by CPI on 1 January each year, consistent with the indexation of the EMSN thresholds[24].

6.2 Operation of the EMSN benefit caps

The EMSN benefit cap will be applied at the item level. This means that the same maximum level of EMSN benefit cap will apply to all claims for that item, regardless of the fee charged by the doctor. The EMSN benefit (if applicable) will be paid ***in addition*** to the standard MBS rebate as per the current arrangements.

All patients are eligible to receive up to the EMSN benefit cap, each time that they have a claim for the service. ***All*** the out-of-pocket costs relating to these items will accumulate

[21] CHERE 2009. EMSN Review Report 2009. pg. vii.
[22] CHERE 2009. EMSN Review Report 2009 pg . vi.
[23] Budget Measures, Budget Papers No. 2. 2009-10 Federal Budget pgs. 289-290
[24] Section 10A of the HIA sets out the method for the indexation of the EMSN thresholds.

towards the EMSN threshold. Patients, and their family members, will continue to receive 80 per cent of their out-of-pocket costs for their other EMSN eligible services. This means that patients will not be disadvantaged for all their other services and all services that are currently covered by the EMSN will continue to be covered by the EMSN.

Under the changes, the method for determining the EMSN benefit will be the same, that is, 80 per cent of the patient's out-of-pocket cost once the patient has reached the EMSN threshold. If this amount is greater than the EMSN benefit cap, then the patient receives the EMSN benefit cap amount. If the calculated benefit is less than the EMSN benefit cap, then the patient receives the calculated benefit (which is equal to 80 per cent of the out-of-pocket costs for the claim).

For example, if it is assumed that the patient has already reached the EMSN threshold and is therefore eligible for EMSN benefits, the following scenario could apply.

Box 6.1 - Application of the EMSN benefit cap

For MBS item 16500, an antenatal attendance, with an MBS Schedule Fee of $43.55 (the increased MBS fee on 1 January 2010, excluding indexation, with a MBS rebate of $37.05) there is a $30 EMSN cap (excluding indexation from 1 January 2010).

Assuming that the patient has already qualified for EMSN benefits, if the doctor charges $100 for this service, under the existing arrangements, a patient will receive an EMSN benefit of $50.40 (80 per cent of their out-of-pocket cost in addition to the $37.05 rebate. This is an MBS benefit of $87.45 in total).

If the patient is charged $100 and the EMSN cap was set at $30, then the person will only receive an EMSN benefit of up to $30 ($37.05 plus the EMSN benefit cap of $30 – a total MBS rebate of $67.05).

For a person charged $70, the EMSN benefit will be $26.40 as this is equal to 80 per cent of their
out-of-pocket costs for the claim ($37.05 plus the EMSN rebate of $26.40 – a total MBS rebate of $63.45). There is no impact on this patient as the EMSN benefit they are entitled to ($26.40) is less than the EMSN benefit cap ($30).

As EMSN benefits are only paid for out-of-hospital services, the EMSN benefit caps are only relevant for out-of-hospital services. The introduction of EMSN benefit caps will not impact on the amount that patients receive through their private health insurance.

6.3 Reasons for capping the selected MBS items

While the Medicare items that are being capped in the 2009-10 Budget were identified in the EMSN Review report as areas having large increases in the fees charged as a result of the EMSN, these areas of expenditure had been a concern for some time. The EMSN Review report found that these services were in a group of services where the majority of the EMSN benefit is going towards funding doctors' increased fees rather than helping patients with their out-of-pocket costs, or having a very high safety net benefit per service.

The EMSN Review report found that between 2003 and 2008, the fees charged by obstetricians for "in-hospital services fell by 6 per cent, while out-of-hospital fees increased by 267 per cent"[25]. Similarly, the EMSN Review report found that "the average in-hospital fees for ART fell by 9 per cent and out-of-hospital fees increased by 62 per cent".

CHERE commented that "this analysis supports the idea that providers have changed their billing practices by switching some of their fees from in-hospital to the out-of-hospital setting"[26].

The EMSN Review report also found that for some Medicare services with high out-of-pocket costs, such as varicose vein treatment, one type of cataract surgery, injection of a therapeutic substance into an eye and some ART services, for every EMSN dollar, 78 cents was spent on meeting doctors' higher fees, rather than reducing patients' out-of-pocket costs[27].

The Medicare item for hair transplantation for the treatment of alopecia was identified in the EMSN Review report as one of the top items for EMSN spend per service[28]. This is confirmed by Medicare data that shows that in some cases, the fee charged for the Medicare item is in excess of $10,000, when the schedule fee is $437.60.

For further information regarding the findings of the EMSN Review report in relation to the selected MBS items, refer to sections 7 to 12.

6.4 Implementation

The EMSN benefit caps will be applied from 1 January 2010, to coincide with the start of the EMSN year. It is important that the Bill is finalised as soon as possible to ensure that patients and practitioners have certainty in relation to their Medicare entitlements. This is particularly important for patients that have an episode of care which spans many months, such as pregnancy.

The EMSN benefit caps were set with reference to the schedule fees for the services, taking into account the variation in time and complexity of providing the service to different patients, and the existing patterns in doctors billing practices and distribution of EMSN benefits for the items.

Each of the services has a different patient profile and circumstances that are individual to those services, which influences the appropriate methodology for setting the EMSN benefit cap. For example, the effect of capping obstetrics items should be examined in the context of the whole patient episode of care, which involves antenatal attendance right through to the management of the birth.

As part of the policy of capping EMSN benefits outlined in the 2009-10 Budget, the Medicare rebates for 15 obstetrics services will be increased at a cost of $157.6 million over four years. This means that from 1 January 2010, all mothers who have a baby delivered by a

[25] CHERE. 2009. EMSN Review Report 2009, pg. 63.
[26] CHERE. 2009. EMSN Review Report 2009, pg. 63.
[27] CHERE. 2009. EMSN Review Report 2009. pg. 70.
[28] CHERE. 2009. EMSN Review Report 2009, pg. 48.

private doctor will receive a standard Medicare rebate 30 per cent higher than the current Medicare rebate.

The Government is also providing funding of $120.5 million over four years through the 2009-10 Budget for the 'Improving the Maternity Service Package'[29]. This package will improve choices for Australian women to access high quality, safe maternity care, and provide support for the maternity services workforce.

As part of this package, patients of appropriately qualified and experienced midwives working collaboratively with doctors will have access to MBS benefits for certain services; and certain medicines prescribed by these health professionals will be subsidised by the Government through the Pharmaceutical Benefits Scheme. A new Government-supported professional indemnity scheme for eligible midwives working in collaborative arrangements will also be established. Legislation to facilitate these new arrangements was introduced into the House of Representatives on the 24 June 2009.

New MBS items for services provided by these eligible midwives will be created. This will include antenatal, birthing and postnatal and collaborative care arrangements between these midwives and obstetricians/GP obstetricians. The details of these MBS items will be finalised in consultation with the professions and specified in secondary legislation. The new Medicare items for midwifery services will also have EMSN benefit caps.

The MBS items for ART services will be restructured to more accurately reflect the phases of an ART cycle, and the costs associated with that phase of treatment. Although, the MBS items and the EMSN benefit caps will change, the overall financial result for the patient should remain the same.

6.5 Consultation

The Department has met with the AMA and NASOG regarding billing issues concerning the EMSN on many occasions since the program was introduced in 2004.

The Department is continuing to work with the profession leading up to the implementation of this measure. The Department is currently working with the ART profession, including members of the IVF Directors Group, to restructure the MBS items for ART services and the EMSN benefit caps to apply to those items. Similarly, the Department will be working with obstetrician groups regarding the new items for obstetrics services.

Different professional groups have highlighted issues in relation to obstetrics and the EMSN through submissions to the Maternity Services Review. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) wrote that the EMSN "has encouraged the move of obstetricians away from public hospitals" and "away from rural and disadvantaged hospitals, towards areas of high income where substantive out-of-pocket charges are sustainable". RANZCOG recommended "capping the rebate amount that any one item can attract through the EMSN" and redistributing funding towards the needs of rural Australia and increasing the Medicare rebates for a number of birth items[30].

[29] Budget Measures, Budget Papers No. 2. 2009-10 Federal Budget pg. 284.
[30] Royal Australian and New Zealand College of Obstetricians and Gynaecologists. 2008. Submission to the Maternity Services Review, pg 88. available from http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-400.

Similarly, the Australian Salaried Medical Officers Federation made its views known to the Department writing that the EMSN has led to a substantial increase in the remuneration available to private obstetricians compared with public obstetricians, which encourages obstetricians to move out of the public sector. It also wrote that there is an urgent need to review the EMSN, especially the open-ended nature of the program which sets no limit of the amount of Medicare benefits that can be claimed.

The Department has also received suggestions from the medical profession regarding possible ways to address the increasing expenditure on obstetrics through the EMSN. Among these suggestions was a recommendation to cap EMSN benefits for obstetrics services.

7. Obstetrics Services

7.1 Medicare funding for obstetric services

Total benefits paid for obstetrics were 1.7 per cent of total MBS expenditure in 2008[31]. Total MBS expenditure on obstetrics services increased from $72.4 million to $227.9 million (an increase of 214 per cent) from 2003 to 2008[32]. This includes funding provided for births and other in-hospital procedures. This increase in expenditure is largely a result of the introduction of the EMSN rather than an increase in the number of obstetrics services or an increase in the number of births in the private sector.

Table 7.1 shows the increase in the Medicare benefits paid for obstetrics services, the increase in the number of services and the number of Medicare funded deliveries. The table shows that the increase in the expenditure on obstetrics is not a direct result of an increase in the number of services funded through the MBS, but is driven by increased EMSN expenditure for obstetrics. For example, between the 2007 and 2008 calendar year there was a four per cent increase in the number of MBS funded obstetrics services, including a two per cent increase in the number of deliveries, but a 15 per cent increase in the Medicare benefits paid for those services. The EMSN Review report found that there has been a one per cent increase per year in the number of private obstetrics services used per capita since the introduction of the EMSN, although this could be explained by an increase in the birth rate at the same time[33].

Table 7.1 - Obstetrics Services and Benefits under Medicare by calendar year*

	Medicare Benefits ($million)	% increase in benefits from previous year	Number of obstetrics services billed to Medicare	% increase in services from previous year	Number of MBS funded deliveries**	% increase in deliveries from previous year
Obstetrics						
2000	60.7		1,462,838		70,003	
2001	66.5	10%	1,473,021	1%	78,410	12%
2002	72.3	9%	1,473,434	0%	84,690	8%
2003	72.4	0%	1,422,727	-3%	82,268	-3%
2004	112.4	55%	1,432,633	1%	82,336	0%
2005	157.6	40%	1,414,410	-1%	84,925	3%
2006	171.9	9%	1,465,424	4%	86,132	1%
2007	198.6	16%	1,510,551	3%	89,645	4%
2008	227.9	15%	1,563,849	4%	91,313	2%

* Medicare data, date of processing.
**sum of services from items 16515-16522, includes delivery by any means, including caesarean sections.

Data from the National Admitted Patient Care dataset shows that between 2005-06 and 2006-07 there was an increase of 6.1 per cent in the number of births in Australia in public hospitals**,** yet there was only an increase in the number of births in the private sector of 1.9 per cent.

Based on the admission status of the patient, the proportion of births to private patients has remained steady at around 33 per cent of total births (taking into account births in private and

[31] Medicare data (date of processing).
[32] Medicare data (date of processing).
[33] CHERE. 2009. EMSN Review Report 2009. pg. 62.

public hospitals where the patient has elected to be a private patient) since 2003-04.[34]. This means that despite the increase of 215 per cent in Government expenditure for private sector maternity care since 2003, there has been no increase in the proportion of births in the private sector.

7.2. Medical Indemnity

Some stakeholders have proposed that the practice costs for obstetricians have increased as a result of increased medical indemnity costs. In 2007-08, the Government spent approximately $12 million through the Premium Support Scheme (PSS) to subsidise the medical indemnity premiums of around 800 obstetricians, gynaecologists and GP obstetricians.

In 2002, the largest medical indemnity provider in Australia, United Medical Protection (UMP) was placed into provisional liquidation with the resulting possibility that many medical practitioners would be unable to find adequate alternative cover. At the same time, medical practitioners were experiencing significant increases in premiums across all medical indemnity providers. In response to this, the Government introduced reforms to ensure a viable and ongoing medical indemnity insurance market.

In January 2003, the Government introduced the Medical Indemnity Subsidy Scheme (MISS) for certain groups of medical practitioners: neurosurgeons, obstetricians, procedural GPs and GP registrars undertaking procedural training. For obstetricians, the subsidy was 50 per cent of the difference between the cost of their premium and the corresponding cost for gynaecologists in the relevant State or Territory who were insured with the same insurer. Prior to this, the Commonwealth Government did not provide any support for medical indemnity premiums for private medical practitioners.

In July 2003, following the initial Medical Indemnity Policy Review, an extended package of measures was introduced to alleviate the impact of high cost claims and to put downward pressure on medical indemnity premiums. The package included the PSS, the High Cost Claims Scheme (HCCS), the Exception Claims Scheme (ECS) and the Run-off Cover Scheme (ROCS).

The PSS was introduced as an enhanced replacement to MISS, assisting eligible practitioners, regardless of speciality, if their gross medical indemnity costs exceed 7.5 per cent of their gross private medical income. The PSS subsidises 80 per cent of any premium costs beyond the 7.5 per cent threshold. Payments under the PSS commenced in mid 2004.

The HCCS minimises the impact that large claims have on medical indemnity insurers. It provides stability for the industry and places downward pressure on premiums, particularly for practitioners in high-risk specialties. Under the HCCS, insurers are reimbursed 50 per cent of the amount of a claim that exceeds $300,000 (up to the limit of the practitioner's cover).

Under the ECS, the Government assumes liability for 100 per cent of damages payable against a practitioner above the practitioner's insurance contract limit, which is currently set at $20 million.

[34] National Admitted Patient Care data 2003-04 to 2006-07

Under ROCS**,** the costs of medical indemnity claims against practitioners who have left private practice are covered by the Government. ROCS is primarily funded by a tax on the premium income of medical indemnity insurers.

7.3 Obstetrics practice

Although the Medicare benefits paid to services provided by a group of doctors does not reflect their net personal income, it is still useful to consider the amount of Commonwealth funding that is being paid for these services, and whether there have been any significant movements over time. Figures on MBS benefits paid do not take into account patient co-payments, or payments for services that are not remunerated through the MBS.

For the top 10 per cent of obstetricians and gynaecologists for Medicare derived income, their average fees charged for Medicare funded services increased by an average of nearly $400,000 each between 2005 and 2008 to $1.8 million. The average MBS benefits paid increased by nearly $255,000 (to $1.1 million) and the average benefits paid through the EMSN increased by more than $200,000 each to $612,000. As the figures above illustrate, that at least for those services billed to the MBS, the average patient out of pocket cost for MBS funded services increased by almost $150,000 for each doctor.

It should be noted that these figures compare the 2005 and 2008 calendar years. The EMSN was introduced in 2004, and it is reasonable to assume that the majority of any 'booking fee' charged by the doctors for the out-of-hospital component of the service had been largely included in the fee charged by the doctors for out-of-hospital services by 2005.

These figures include MBS benefits paid for both in and out-of-hospital services. Therefore the figures are not explained by doctors charging more for out-of-hospital services and less for in-hospital services. The costs of hospital accommodation and the other staff involved in the actual delivery of a child are covered either by PHI, or through payments directly to other doctors, for example where there is an anaesthetist involved in a caesarean section.

The President of the AMA noted at the Senate hearing of 14 July 2009, that the Department had said that the increase in EMSN expenditure was not a result of the top doctors increasing their fees, it was as a result of the bottom doctors increasing their fees, and that the highest charging doctors have not put up their fees.

However, Medicare data shows that doctors at the top end have continued to increase their fees. Between January 2008 and January 2009, those doctors charging at both the 75th and the 95th percentile increased their fees by around 14%. The reason that they can continue to increase their fees, is that their patients will be over the EMSN threshold as soon as they are charged for this item as the fees charged are so high. For these patients, they are only responsible for $20 of every $100 fee increase.

7.4 Findings of the EMSN Review Report relating to obstetrics

The EMSN Review report found that obstetrics was an area of the MBS which has had large increases in the fees charged for services. The EMSN Review report found that "over the period after the introduction of the EMSN, average fees increased by 7.4 per cent per year and 86 per cent of this increase was due to the EMSN. That is, the EMSN was directly

responsible for a 6.4 per cent increase in fees per year"[35]. Other key findings from the EMSN Review report relating to obstetrics are included in Box 7.1.

Box 7.1 - Findings of the EMSN Review Report relating to Obstetrics

- In 2007, over 30 per cent of total EMSN benefits went towards private obstetric services.
- From 2003 to 2007, total Medicare benefits for obstetric services increased from $80.5 million to $199.5 million, with 83 per cent of this increase attributable to the EMSN.
- The in-hospital component of this benefit grew by 8 per cent over that period while the out-of-hospital component grew by 313 per cent.
- The increase in the EMSN thresholds in 2006 had a negligible impact on the amount of EMSN benefits for private obstetric services.
- One pregnancy related ultrasound was part of a group of services that were associated with high out-of-pocket costs for which the EMSN Review report found that for every dollar spent on the EMSN in 2008, providers received 78 cents and patients received 22 cents (see Appendix B for the full list of items in this group).
- Between 2003 and 2008, average in-hospital fees for obstetrics fell by 6 per cent and out-of-hospital fees increased by 267 per cent.
- For every dollar spent on the EMSN for private obstetric services, providers increased their fees by $1.39 and patients out-of-pocket costs increased by 39 cent. However, there is evidence that some obstetricians were charging a booking fee that was not covered by Medicare and therefore wasn't taken into account when estimating fees charged prior to the introduction of the EMSN.
- Assuming a booking fee was charged prior to the introduction of the EMSN, for every dollar spent on the EMSN for obstetrics services, providers received 33 cents and 67 cents went towards reducing patient out-of-pocket costs. This is a conservative estimate[36].

7.5 Capping EMSN benefits for Obstetrics services and the impact on patients

The package of services that a patient will receive during an episode of pregnancy care will vary between patients, depending on their health status and their personal circumstances and requirements. However, as an indicative measure, patients that are currently charged at the average fee for obstetrics services across an episode of care may be out-of-pocket by $550 (assuming that the patient needs to spend $500 before qualifying for the EMSN threshold). This estimate does not include costs and rebates associated with pregnancy pathology tests or diagnostic imaging. It should be noted that unless the pregnancy service is routinely provided by an obstetrician, such as some ultrasounds, it will not be subject to EMSN caps, meaning that the patients will be no worse off as a result of the introduction of capping these items. It should also be noted that some patients will be better off under this measure as a result of the increases in the standard Medicare rebates for most obstetric items.

Several examples which demonstrate the impact of the MBS rebate increase and the application of the EMSN benefit caps are available at Appendix D.

Some stakeholders appear to be under the impression that the EMSN benefit caps for obstetrics services will prevent many obstetrics patients from reaching the EMSN threshold,

[35] CHERE. 2009. EMSN Review Report 2009. pg. 69.
[36] The EMSN Review used Medicare data based on date of service. The fees used in the analysis were adjusted for inflation to analyse the data in constant 2007 equivalent dollars.

therefore effectively removing access to EMSN benefits. Patients will reach the threshold in the same manner that they already do. That is, all of their out-of-pocket cost for the EMSN eligible services will accrue towards the EMSN threshold. There is no limit on the amount of out-of-pocket cost that can be counted towards the threshold. It is not estimated, that as a result of the changes, less obstetrics patients will qualify for benefits. The only thing that is changing is that there will be a limit on the amount of benefit that will be paid under the EMSN once the patient reaches the applicable EMSN threshold. Patients and members of their registered family will continue to receive 80 per cent of their out-of-pocket cost for their other EMSN eligible services (for the services that do not have a cap). This means that they will not be disadvantaged for any of their other EMSN eligible services. Patients will still receive the standard MBS benefit for the service, which in many cases will be higher under these changes. Any EMSN benefit will be paid in addition to the standard MBS rebate.

In its submission and evidence to the Senate Committee the AMA raised concerns that the Government modelling "erroneously includes some notional allocation of EMSN benefits for in-hospital services". EMSN benefit caps have been placed on all obstetrics services, including services which are usually provided on an in-hospital basis. Although the vast majority of deliveries are performed in-hospital, Medicare data shows that there are some services provided out-of-hospital. EMSN benefit caps have been placed on these items to ensure that there is no perverse financial incentive to provide any services on an out-of-hospital basis. Although, these items will have EMSN benefit caps, the calculation of savings does not assume any savings from applying a cap to these items or the payment of EMSN benefits for these items, as current EMSN expenditure in this area is very small.

The increase in the Medicare rebates and the level of the EMSN benefit caps for the obstetrics items are at Appendix A.

8. Assisted Reproductive Technology services

ART services involve the application of laboratory or clinical techniques to gametes and/or embryos for the purposes of reproduction. ART is performed by medical practitioners to assist people who are having difficulty naturally conceiving and carrying a baby to full term. ART can involve many different medical procedures, using differing paths to conception. A cycle of ART is therefore not the same for every woman. There are four main types of cycles. IVF is one form of ART. A further explanation of the four main types of ART cycles is available at Appendix E.

8.1 Medicare funding for ART services

ART items have been listed on the MBS since 1989. Medicare expenditure on ART services has grown from $39.3 million in calendar year 2000, to $202.2 million in calendar year 2008, increasing most significantly since the introduction of the EMSN[37].

Table 8.1 ART Services and Benefits under Medicare by calendar year

Calendar Year	Medicare Benefits ** ($ million)	% increase in expenditure from previous year	Services billed to Medicare	% increase in services from previous year
2000	39.3		131,004	
2001	43.3	10%	135,187	3%
2002	46.0	6%	139,086	3%
2003	50.0	9%	145,517	5%
2004 *	78.6	57%	159,181	9%
2005	108.4	38%	182,834	15%
2006	119.3	10%	195,557	7%
2007	158.9	33%	228,248	17%
2008	202.2	27%	252,813	11%

*Extended Medicare safety net introduced in March 2004.
**Note that this does not include other expenditure on ART such as PBS benefits.

The EMSN Review report found that there had been substantial growth in demand for ART services of almost 10 per cent per annum since the introduction of the EMSN[38]. Medicare figures show that between 1 January 2008 and 31 December 2008, 34,292 women had at least one cycle of ART[39].

The success of an ART cycle cannot be determined using Medicare data, however Table 8.2 shows that in 2006 (the latest year for which data is available) approximately 19.7 per cent of treatment cycles resulted in a birth.

[37] Medicare data (date of processing).
[38] CHERE. 2009. EMSN Review Report 2009. pg. 62.
[39] Medicare data (date of processing).

Table 8.2 - Treatment cycles, pregnancies, deliveries, and babies by calendar year[40]

Calendar Year	Treatment Cycles	Pregnancy	Deliveries	Babies	% of treatment cycles that result in a birth
2002	36,483	7,577	5,713	6,816	18.7%
2003	39,720	8,365	6,409	7,589	19.1%
2004	41,904	8,794	6,932	7,913	18.9%
2005	51,017	10,450	8,215	9,283	18.2%
2006	53,543	12,086	9,277	10,522	19.7%

Source: National Perinatal Statistics Unit, AIHW 2006.

For the top 10 per cent of ART doctors by Medicare derived income, the average fees charged for Medicare funded services increased by an average of $1.7 million each between 2005 and 2008 to $5.8 million. The average MBS benefits paid increased by $1.3 million (to $4.5 million) and the average benefits paid through the EMSN increased by around $870,000 each to more than $2.1 million. As these figures illustrate, for those services billed to the MBS, the average patient out of pocket cost for MBS billed services increased by $380,000 per doctor. Although there has been an increase in the number of ART services, there has been a similar increase in the number of ART doctors, so this increase is not a result of significant increases in the number of services provided by these doctors.

This analysis is based on a comparison of the 2005 and 2008 calendar years, well after the introduction of the EMSN, and does not take account of the significant increases in fees and expenditure being observed in the first six months of 2009.

The Department acknowledges that the MBS payments for services provided by ART doctors set out above does not equal the personal income of these doctors and there are significant practice costs in providing ART. However, the payments do not include patient co-payments, payments for services that are not remunerated through the MBS, or facility and accommodation fees that are paid to the ART clinics for in-hospital ART services.

Some members of the profession have indicated that the high level of MBS derived income for some doctors is because of what can be described as 'headline billing' and that the costs for some embryology and other costs are being recorded against the MBS billing for a small number of doctors. As set out earlier in this submission, this is not legal. According to Medicare data, the MBS derived income for the 'top 10 per cent' referred to above has actually fallen as a percentage of total paid to ART doctors. This demonstrates that the phenomenon of 'headline billing' cannot account for the extremely large proportion of benefits flowing to some practitioners.

These figures include both in and out-of-hospital services, to ensure it is not reflective of a distribution of fees between in-hospital and out-of-hospital services.

[40] Wang, Y.A, Dean, J.H, Badgery-Parker, T & Sullivan, E.A. 2008. Assisted reproduction technology in Australia and New Zealand 2006. Assisted reproduction technology series no 12. AIHW cat. No. PER 43. AIWH Perinatal Statistics Unit

8.2 ART practice in Australia

In Australia there is no national legislation that covers the accreditation of ART clinics, and only three states have specific legislation regarding regulation of ART services – Western Australia, Victoria and South Australia. It should be noted that the National Health and Medical Research Council provide ethical guidelines for ART and these guidelines form the basis of the Reproductive Technology Accreditation Committee (RTAC) Code of Practice which clinics are required to comply with if it is to be RTAC accredited[41].

Although RTAC accreditation is not mandatory for all ART clinics, those clinics that use embryos (those clinics that use IVF) are required to be RTAC accredited under the *Research Involving Human Embryos Act 2000* and it is currently a requirement for ART clinics to receive federally funded ovarian stimulation drugs. Unaccredited clinics are unable to undertake most ART services except Artificial Insemination (AI). The RTAC Code of Practice sets out the minimum standards that a clinic is required to comply with in order to be accredited. For example, a clinic is required to provide evidence of a minimum level of staffing with specific qualifications (e.g. a medical director, a scientific director and senior counsellor) and have specific policies in place in relation to the transfer of multiple embryos and storage of gametes and embryos.

One of the suggestions put forward by stakeholders was that there is increased costs associated with accreditation and compliance. A recent study found that there was no clear relationship between the level of regulation and public funding of ART and the costliness of an episode of ART treatment (regardless of the payer of the treatment)[42]. Furthermore, there are other regulated sectors within the MBS, such as radiation oncology, diagnostic imagining and pathology which have not shown fee increases to the same extent as the speciality of ART.

The IVF Directors Group and the AMA in their joint evidence to the Senate Committee defended the high fee increases in ART procedures, stating that IVF is a uniquely capital and labour intensive area of health care.

There are numerous complex diagnostic and therapeutic procedures that are labour intensive and require regular large capital investments due to technological developments, yet ART is the only area to have systematically increased its fees to such a large extent.

Radiation oncology clinics employ large numbers of staff, similar to IVF clinics, and the investment made in radiation and chemotherapy machinery is substantially higher than the capital investments in IVF. Likewise, pathology and diagnostic imaging also have high capital costs and require large numbers of staff. All of these fields of medicine are labour intensive and face technological change resulting in ongoing capital investment.

Prima facie, costs of IVF clinics should be increasing consistently with other industries, particularly the medical sector. If they are not, then the IVF providers should be able to identify why not and provide information on these cost drivers. Most efficient big businesses

[41] NHMRC. 2008. Regulation of Assisted Reproductive Technology. Available at http://www.nhmrc.gov.au/research/embryos/information/art.htm

[42] Georgina M. Chambers, Elizabeth A. Sullivan, Osamu Ishihara, Michael G. Chapman, G. David Adamson. 2009. The economic impact of assisted reproductive technology: a review of selected developed countries. Fertility and Sterility Vol. 91(6): 2281-2294.

should be able to identify their cost drivers and provide evidence on how these drivers have moved outside normal market increases.

It is also interesting to note that IVF clinics are attracting the interest of large financial investment corporations including Macquarie Bank, ABN Amro and Quadrant Private Equity all of which have invested in IVF clinics since the introduction of the EMSN. This indicates that ART is a very profitable industry.

The Medicare benefit is intended to be a patient benefit to assist them in paying for a clinically relevant service that they are receiving. It is not intended to help pay for research to potentially benefit other people into the future. The National Health and Medical Research Council (NHMRC) expected to pay around $1.2 million in research grants on ART/IVF in 2008. AusIndustry has also provided significant funding to support ART clinics develop new technology.

If the fee increases for ART services were truly driven by technology and labour costs we would expect to see similar fee increases in other areas of medicine such as radiation oncology, pathology or diagnostic imaging. The fee increases in these areas have been far more modest than in ART. What is unique about ART is not the intensity of capital and labour investment, but only the systematic increases in fees charged to patients to take advantage of the unlimited government subsidy.

There are many services associated with ART treatment that are not subsidised by Medicare. These include:[43]

- Embryo storage $300 per annum
- Blastocyst culture $600
- Assisted hatching $260
- Pre-implantation Genetic Diagnosis $600
- Donor sperm, donor eggs and embryos $100
- Non PBS subsidised drugs $300
- Theatre fee $450
- Accommodation fee $260

These costs have never been covered by Medicare, either before the EMSN or after the EMSN. It is not appropriate under legislation for fees that are not related to the service being provided to be included in the fees for the Medicare service. If such a practice was detected, this would be referred to Medicare Australia for investigation and would become a compliance issue.

It is left to the practitioners (and patients) discretion whether these fees are applicable and fees will continue to be a private arrangement between the practitioner and the patient and will not be impacted by the EMSN benefit cap.

[43] Estimated costs are derived from available public information and are indicative only.

8.3 Overseas arrangements for ART funding

Most developed countries have recognised infertility as a medical condition and have made provisions for infertility treatment within national health policies, with Australia, Austria, Denmark, Finland, France, Germany, Iceland, the Netherlands, Norway, Sweden and the United Kingdom (UK) providing public funding for IVF.

Key variations in policies in developed countries include: restrictions to ART funding according to the women's age or prior number of failed cycles; and the maximum number of embryos transferred at one time.

Many countries place restrictions on public funding for ART based on women's age. In the UK and Germany, women must be under 40 years of age to be eligible for reimbursement. In the UK, women aged between 23 and 39 years are eligible to receive one free IVF cycle funded by the National Health System, with arrangements varying between area health services. In the US there is no public funding for ART treatment.

In New Zealand, additional public funding has been provided for a second treatment cycle to those eligible patients whose first treatment cycle does not result in a live birth.

Australia provides Medicare funding for an unlimited number of ART cycles. Cycles are not restricted by the age of women. Australia is the only country in the world to provide this level of government support.

8.4 Multiple embryo transfers

Many stakeholders are concerned that capping EMSN benefits for ART services will lead to an increase in the number of embryos implanted at the one time and therefore an increase in the number of multiple births. The evidence used to defend this assertion is the fact that there is a higher national rate of multiple embryo transfers in some other countries, where the cost of ART treatment for the patient is much higher or caps are placed on the number of cycle for which funding is provided. In these cases, there may be an incentive to implant additional embryos to maximise the likelihood of pregnancy as it may be their 'last chance'. This is not the case in Australia where access is not being reduced or limited by number of cycles or age.

It should be noted that the RTAC Code of Practice provide that ART clinics must minimise the incidence of multiple pregnancy. Under this Code, clinics are expected to recommend to patients that no more than one embryo or oocyte is transferred in the first treatment cycle where the woman is under 35 years at the time of the egg collection and that clinics must ensure that no more than two embryos of oocyte are transferred in a treatment cycle in a woman under the age of 40 years. The guidelines also dictate that clinics must provide patients with information about the "economic, medical, social and psychological hazards associated with multiple pregnancy"[44].

The Department does not agree that capping EMSN benefits for ART services will directly result in an increase in multiple pregnancies.

[44] Reproductive Technology Accreditation Committee. 2008. Code of Practice for Assisted Reproductive Technology Units. Available at http://www.fertilitysociety.com.au/rtac/accreditation-documents/

8.5 Findings of the EMSN Review Report relating to ART

ART services were identified in the EMSN Review report as an area of concern. The EMSN Review report found that between 2003 and 2008, the fees charged for ART services fell by 9 per cent for in-hospital services, whilst the fees charged for out-of-hospital services increased by 62 per cent[45]. Further findings of the EMSN Review report relating to ART can be found in Box 8.1.

Box 8.1 - Findings of the EMSN Review Report relating to ART services

- In 2007, 22 per cent of total EMSN benefits went towards ART services.
- EMSN funding of ART services increased from $29 million in 2004 to $72 million in 2007 (adjusted for inflation).
- The EMSN appears to have made services more affordable for some, including people receiving ART services, and the demand for ART services increased substantially after the introduction of the EMSN.
- From 2003 to 2007, total Medicare benefits for ART services increased from $55.5 million to $158.7 million, with 70 per cent of this increase attributable to the EMSN. The remainder is explained by increased utilisation.
- The increase in the EMSN thresholds in 2006 had a negligible impact on the amount of EMSN benefits for ART services.
- A number of ART items were part of a group of services that were associated with high out-of-pocket costs for which the EMSN review report found that for every dollar spent on the EMSN in 2008, providers received 78 cents and patients received 22 cents (see Appendix B for the full list of ART items in this group).
- In the first year after the introduction of the EMSN average fees for ART services increased by 21 per cent, and around three quarters of this increase was attributable to the EMSN.
- Over the period after the introduction of the EMSN, average fees increased by 10.3 per cent per year and half of this increase was due to the EMSN. That is, the EMSN was directly responsible for a 5 per cent increase in fees per year. Between 2003 and 2008, average in-hospital fees for assisted reproductive services fell by 9 per cent and out-of-hospital fees increased by 62 per cent.
- For every dollar spent on the EMSN for ART services, providers received 52 cents and 48 cents went towards reducing patient out-of-pocket costs (assuming no booking fee).

8.6 Capping EMSN benefits for ART services and the impact on patients

An independent review of ART conducted in 2006 recommended that current Medicare items be reviewed to ensure that the items reflect current clinical practice. As part of this Budget measure, the Department is working with the ART profession to restructure the items to better reflect the stages involved in a treatment cycle and the costs. One of the aims of this restructure is to assist ART patients with cash flow relating to their ART treatment, as the cost of treatment will be spread across the phases of the treatment cycle, with patients being able to claim a Medicare rebate at each stage of the cycle rather than waiting until the completion of their treatment cycle to claim their Medicare rebate. Although the MBS items for ART will change and the level of the EMSN benefit caps will change, the overall

[45] CHERE. 2009. EMSN Review Report 2009. pg. 63.

financial impact on the patient should remain the same. In some cases, the standard MBS rebate that the patient can receive may be more than the rebate that is currently available.

The majority of patients will not be impacted by these changes if doctors' charges remain at current levels. A patient receiving a typical cycle of treatment who is billed at the median level across all of the items in a treatment cycle will receive the same level of government benefit as they do now. On average, patients are charged $6,000 or less for a typical IVF cycle, however some patients are charged in excess of $10,000. Patients that are charged around $6,000 or less should not be worse off under these changes.

Many stakeholders have quoted that patients' out-of-pocket costs will increase from $1,000 per cycle to $3,000 per cycle under the Budget measure. This is incorrect. It may be possible that there is confusion about the application of the EMSN benefit caps.

Patients will still receive the standard Medicare rebate for the service. An EMSN benefit of up to the EMSN benefit cap amount will be paid ***in addition*** to the standard Medicare rebate.

ART can involve many different medical procedures, using differing paths to conception. Therefore, a treatment cycle of ART is not the same for every woman and each woman may also undergo different treatment cycles to achieve a pregnancy. Appendix F provides an example showing that a patient charged at the current median fee will not be worse off under these changes.

One of the issues raised by the IVF Directors Group at the hearing was that before the EMSN there were a number of non-Medicare refunded services, such as a booking fee, that are provided as part of an ART cycle and that these fees were not considered as part of the CHERE analysis. It should be noted that CHERE conducted a sensitivity analysis for ART services to assess the impact of the EMSN on out-of-pocket costs including a booking fee. During consultations with the AMA and other professional groups, representatives from NASOG informed the consultants that there was a non-Medicare booking fee for ART services prior to the introduction of the EMSN. It should be noted that the Department does not have evidence of the existence of a booking fee being charged to ART patients prior to the EMSN. In fact there has been a Medicare item for the planning and management of an ART cycle (commonly referred to as the 'booking fee') in the MBS since 1990. The sensitivity analysis used two scenarios - where a booking fee was charged to ART patients prior to the EMSN and the situation where no booking fee was charged. Assuming that there was a booking fee, the EMSN Review report found that for every dollar spent on the EMSN for ART services, 31 cents went to higher fees and 69 cents went to reducing out-of pocket costs for patients. If it is assumed that there is no booking fee, the CHERE results indicated that for every EMSN dollar, 52 cents went to providers' fee and 48 cents went to assisting patients with their out-of-pocket costs[46].

[46] CHERE. 2009. EMSN Review Report 2009. pg. 67.

9. Cataract Surgery

The item for the most commonly performed cataract surgery will have an EMSN benefit cap of $100 (indexed from 1 January 2010). EMSN benefit caps are not being introduced for other cataract items.

Box 9.1. Current item descriptor for item 42702

42702	LENS EXTRACTION AND INSERTION OF ARTIFICIAL LENS, excluding surgery performed for the correction of refractive error except ***for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) **Fee:** $831.60 **Benefit:** 75% = $623.70 85% = $763.50

The cap on this item will not impact on the majority of patients as less than 5 per cent of services (5,142 services out of a total of 123,441 in 2008) are provided out-of-hospital. It is even the case in rural and remote areas that the majority of services are provided on an in-hospital basis. Appendix G sets out greater detail about the number of out-of-hospital services by state and rurality.

In 2008, EMSN expenditure on this item was $1.48 million, with EMSN benefits paid for around 1,750 services. Of these services approximately 1,600 services were associated with an EMSN benefit in excess of the EMSN benefit cap that is being introduced[47].

The EMSN Review report found that this service was in a group of items where for every EMSN dollar spent, 78 cents was going to the practitioner in the form of higher fees and only 22 cents went to the patient to assist with their out-of-pocket costs[48].

The Royal Australian and New Zealand College of Ophthalmologists has previously provided advice to the Department that this procedure should be performed in an appropriately accredited facility. Although, there are situations where it may be appropriate to perform the procedure out-of-hospital, providing a financial incentive for the procedure to be performed out-of-hospital may have safety implications for some patients.

9.1 2009-10 Budget measure relating to a reduction in the MBS fee for cataract surgery

Although the Bill being considered as part of this Inquiry is not related to a decision taken by Government to adjust the MBS schedule fees for cataract procedures announced in the 2009-10 Budget, some background information has been included. The Government announced in the 2009-10 Budget that the fees for a number of procedural items that are able to be performed more quickly and safely due to improvements in technology will be adjusted to reflect a more appropriate level of remuneration[49]. This will save $153.4 million over four years (only a portion of this amount is related to the fee reduction for cataract surgery).

As part of the 'Ensuring the appropriate use of clinical procedures and adjusting to modern technologies' measure, the fee for the most commonly performed cataract procedure, item 42702, will be reduced by about 50 per cent from $831.60 to $416.85. The fees for the other cataract items will also be amended in negotiation with the ophthalmology profession within the funding allocation. A new item will also be introduced for undertaking complex cataract

[47] Medicare data (date of processing).
[48] CHERE. 2009. EMSN Review Report 2009. pg. 70.
[49] Budget Measures, Budget Paper No. 2. 2009-10 Federal Budget pgs 295

procedures with a schedule fee of $850.75 in recognition that some procedures are more complex and time intensive.

The MBS schedule fees for cataract surgery are being adjusted to align the schedule fee to reflect the reduction in time and complexity. When the MBS items for cataract surgery were introduced, the MBS Schedule fees were reflective of a longer operative time. Intraocular lens technology and a strong growth in cataract surgery have improved techniques and equipment associated with performing these services. When the surgery was first performed, the procedure would take approximately 45 minutes, but now it typically takes 15 – 20 minutes[50].

The fees for cataract surgery currently result in a disparity between this relatively straight-forward procedure and other more specialised procedures which attract a similar fee such as skull and spinal surgery, which take longer and carries a higher level of risk, yet attracts the same level of remuneration.

[50] National Health Service (2000). Action on cataracts: Good practice guidance. Accessed from www.doh.gov.uk.; Koch, Doug and Spalton, David (2000). "The constant evolution of cataract surgery", in the *British Medical Journal*.

10. Injection of a therapeutic substance into the eye

The item for the injection of a therapeutic substance into the eye, often claimed for the treatment of macular degeneration, will have a cap of around $80.00 under the measure. This amount will be indexed from 1 January 2010. Capping EMSN benefits for this item will save $16 million over four years.

Box 10.1 - Item descriptor for item 42740

42740	PARACENTESIS OF ANTERIOR OR POSTERIOR SEGMENT (including the vitreous) OR BOTH, for the injection of therapeutic substances, or the removal of aqueous or vitresous for diagnostic purposes, 1 or more of (Anaes.) (Assist.) (*See para T7.2 of explanatory notes to this Category*) **Fee:** $277.85 **Benefit:** 75% = $208.40 85% = $236.20

In 2008, EMSN expenditure on this item was $3.85 million, with EMSN benefits paid for just under 20,000 services. Of these services approximately 16,000 services were associated with an EMSN benefit in excess of the EMSN benefit cap amount[51]. The average EMSN benefit paid per out-of-hospital service was $77 in 2008.

The EMSN Review report classified item 42740 as a Medicare item with high EMSN benefits. This means that the item was in the top 40 in terms of EMSN benefits paid each year since the EMSN was introduced. The item was also identified as an item in a group of items with high out-of-pocket costs (defined as out-of-pocket costs more than $50 per service). The EMSN Review report found that for items in this category, for every EMSN dollar spent, around 78 cents went towards higher fees and 22 cents went towards reducing patients' out-of-pocket costs[52].

The EMSN Review report also identified Item 42740 was as one of the top 20 Medicare items in terms of the amount of EMSN benefits paid in 2007.

[51] Medicare data (date of processing).
[52] CHERE. 2009. EMSN Review Report 2009. pg. 70.

11. Hair transplants

The item for the hair transplantation for the treatment of alopecia will have a cap of around $150.00 under the measure. This amount will in indexed from 1 January 2010. Capping EMSN benefits for this item will save $0.1 million over four years.

Box 11.1 - Item description for item 45560

45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.) **Fee:** $437.60 **Benefit:** 75% = $328.20 85% = $372.00

In 2008, EMSN expenditure for hair transplantation was around $660,000, with only around 160 services attracting an EMSN benefit[53].

The EMSN Review report found that item 45560 had the highest average EMSN benefit per service of any item in the MBS averaging $3,288 per service in 2007[54].

Table 10.1 shows that before the EMSN was introduced the fee for item 45560 was 2.3 times higher for in-hospital services than for out-of-hospital services. While the average in-hospital fee fell by 14 per cent from 2003 to 2008, the out-of-hospital fee rose by 350 per cent. By 2008 the out-of-hospital fee was almost 2.3 times higher than in-hospital fees.

The data also shows that between 2003 and 2008, the number of in-hospital services has fallen from 24 to 16 (a reduction of 33 per cent), while the number of out-of-hospital services has increased from 115 to 187 (63 per cent).

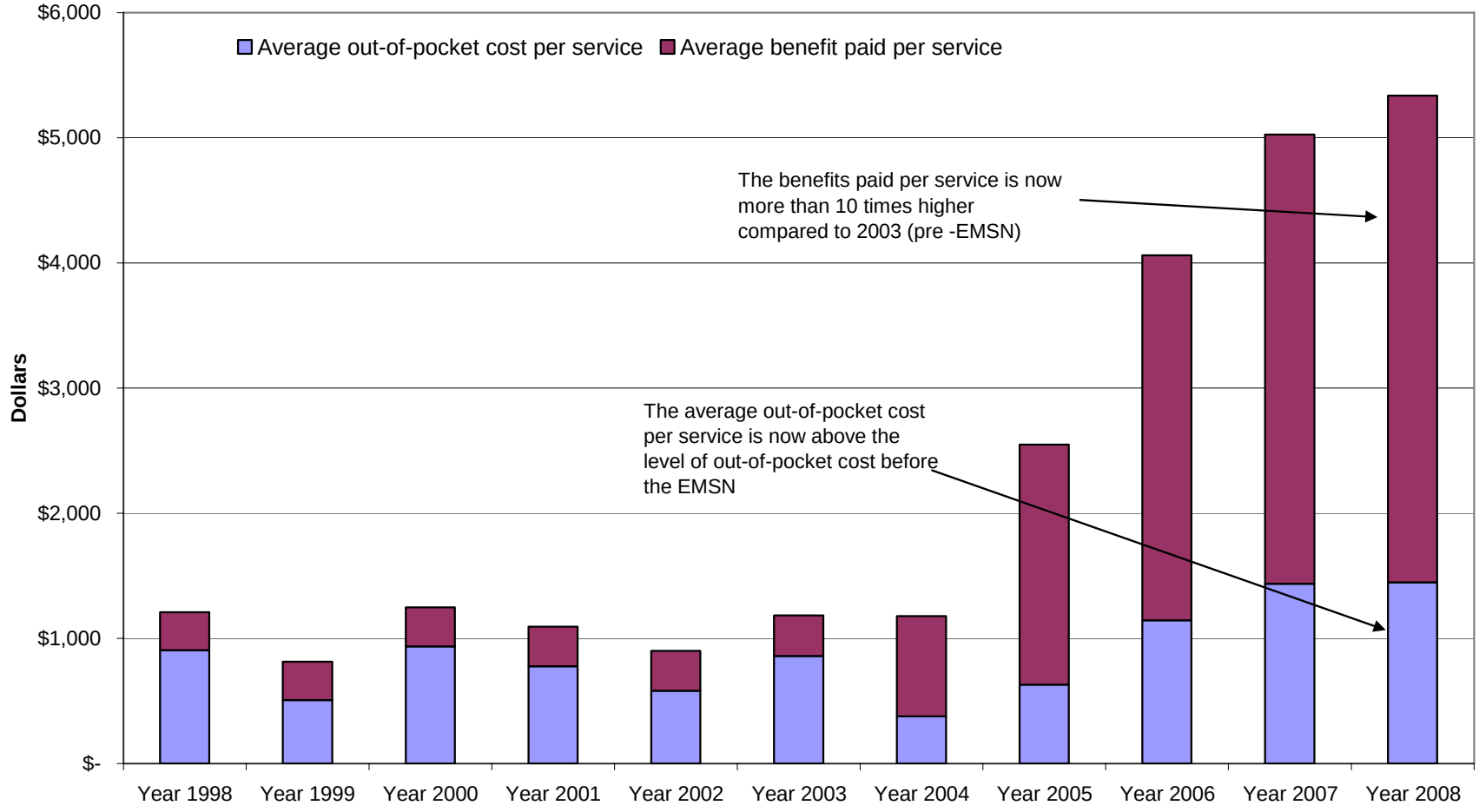
Table 11.1 – Item 45560 Fee charged and number of services 2003 and 2008, in-hospital and out-of-hospital services.

	All services		In-hospital		Out-of-hospital	
Year	Number Services	Average Fee	Number Services	Average Fee	Number Services	Average Fee
2003	139	$ 1,452.17	24	$ 2,735.04	115	$ 1,184.45
2008	203	$ 5,099.98	16	$ 2,344.33	187	$ 5,335.76
Change	46%	251%	– 33 %	–14%	63%	350%

Medicare data (Figure 11.1) shows that the average out-of-pocket cost for this service has increased since the introduction of the EMSN, despite increased MBS expenditure and an increase in the average benefit paid for the service[55].

[53] Medicare data (date of processing).
[54] CHERE. 2009. EMSN Review Report 2009. pg. 48.
[55] Medicare data (date of processing).

Figure 11.1- Average benefits paid and average out-of-pocket costs per service for item 45560 – Hair Transplantation



Hair transplantation for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness
Fee: $437.60 **Benefit:** 75% = $328.20 85% = $372.00

12. Varicose veins

The item for the treatment of varicose veins using sclerotherapy will have a cap of around $110.00 under the measure. This amount will be indexed from 1 January 2010. Sclerotherapy involves the injection of a sclerosant (substance which irritates the walls of the blood vessel causing it to stick together and causing the inner lining of the vessel to disappear) directly into the blood vessel. This is generally considered to be a minor and routine procedure[56]. There were 57,990 services for item in 2008, with only 120 of these services provided in-hospital.

Capping EMSN benefits for this item will save $13.7 million over four years.

Box 12.1 - Item descriptor for item 32500- treatment of varicose veins

32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation – 1 or both legs – not being a service associated with any other varicose vein operation on the same leg (excluding after-care) – to a maximum of 6 treatments in a 12 month period (Anaes.) **Fee:** $101.45 **Benefit:** 75% = $76.10 85% = $86.25

In 2008, EMSN expenditure on this item was $7.11 million, with EMSN benefits paid for around 21,000 services. Of these services approximately 16,500 services were associated with an EMSN benefit in excess of the EMSN benefit cap amount[57]. The average EMSN benefit paid per out-of-hospital service was $122.

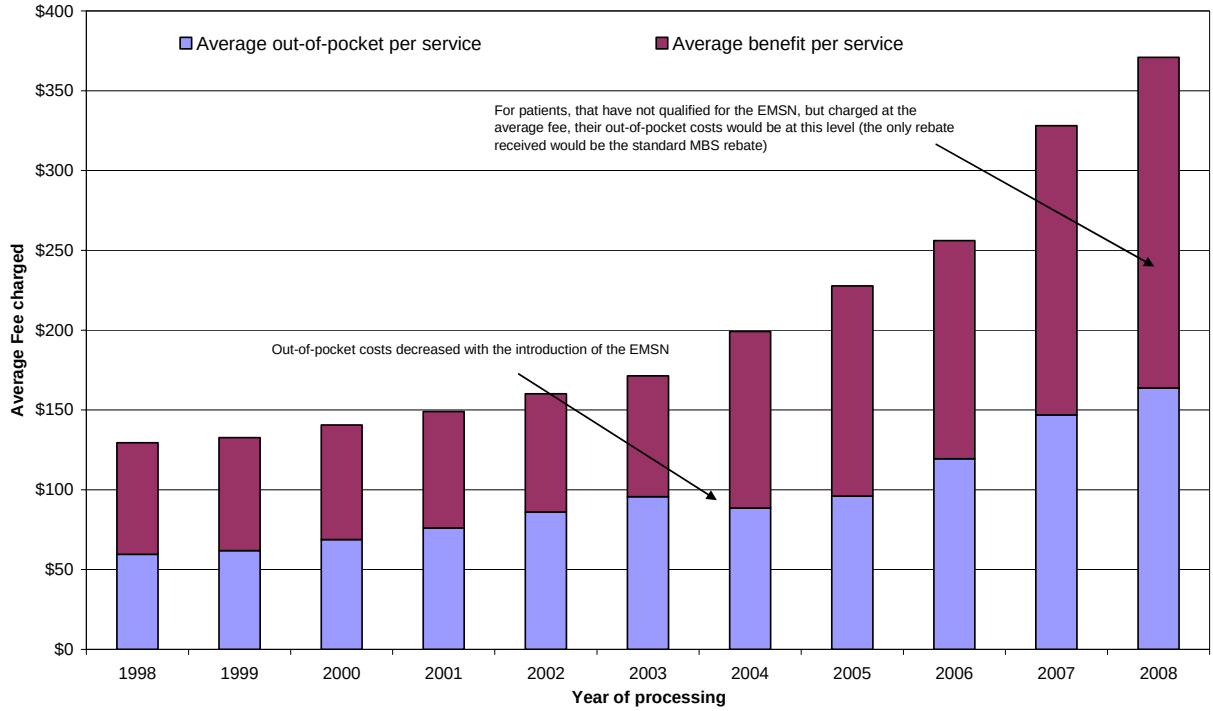
The EMSN Review report classified item 32500 as a Medicare item with high EMSN benefits. This means that the item was in the top 40 in terms of EMSN benefits paid each year since the EMSN was introduced. The EMSN Review report found that for items in this category, for every EMSN dollar spent, around 78 cents went towards higher fees and 22 cents went towards reducing patients' out-of-pocket costs[58].

The EMSN Review report also identified Item 32500 was as one of the top 20 Medicare items in terms of the amount of EMSN benefits paid in 2007[59].

Medicare data (Figure 11.1) shows that the average fee charged for item 32500 has increased 116 per cent from 2003 to 2008. Those people that do not qualify for EMSN benefits for this service are now faced with high out-of-pocket costs if they are charged at the average fee for this service. Similarly, even those patients who are charged at the average fee and receive EMSN benefits for this item, are faced with higher out-of-pocket costs for this service, despite the increase in the amount of benefit paid.

[56] Australasian College of Phlebology. http://www.phlebology.com.au/forms/selmenu.aspx?selmenu=8
[57] Medicare data based on date of processing
[58] CHERE. 2009. EMSN Review Report 2009. pg. 70.
[59] CHERE. 2009. EMSN Review Report 2009. pg. 47.

Figure 12.1- Item 32500 - Average out-of-pocket costs and average benefit paid per service



Item 32500 Treatment of varicose veins where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques
Fee: $101.45 **Benefit:** 75% = $76.10 85% = $86.25

13. **Conclusion**

At the time that the EMSN was introduced the stated purpose of the program was to "protect all Australians from high out-of-pocket expenses"[60]. The EMSN has made some services more affordable, such as for cancer patients; however there are some areas where there have been extraordinary increases in fees and expenditure. The EMSN Review report found that:

> "The Medicare program caps the amount of benefits per services. The EMSN, on the other hand, provides benefits that increase with provider fees, regardless of how high those fees may be. This feature has resulted in significant increases in provider fees for some services and has meant that patients do not receive the full benefit of the EMSN"[61].

The EMSN Review report stated that the fee increases have meant that there is considerable leakage of Government benefits towards providers' incomes, rather than reduced costs for patients[62]. The *Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009* will once again provide a cap on the Government contribution for some medical services and directly target those areas identified in the EMSN Review report. The saving generated through capping the items identified in the 2009-10 Budget will generate savings of more than $450 million. This Bill is important to provide a mechanism by which Government can responsibly manage expenditure under this program and ensure its ongoing sustainability for all Australians.

[60] Hansard. House of Representatives. 4 December 2003. Second Reading for the *Health Legislation Amendment (Medicare) Bill 2004*
[61] CHERE. 2009. EMSN Review Report 2009. pg. vii.
[62] CHERE. 2009. EMSN Review Report 2009. pg. 77.

Appendix A – Table of MBS items and the indicative EMSN benefit caps

Note that the patient is eligible to receive the standard MBS rebates and up to the EMSN benefit cap for each service. For example, for an antenatal attendance, the patient can receive $37.05 plus $30 for each service.

Table of Obstetrics services and EMSN benefit caps

Item Number	Description of service	Fee increase	Current Schedule Fee	New Schedule fee 1 January 2010 (excluding indexation) [63]	EMSN Cap (excluding indexation)[64]
16400	Antenatal attendance by a nurse or midwife on the behalf of a medical practitioner	10%	$ 22.90	$ 25.20	$ 10.00
16500	Antenatal attendance	10%	$ 39.55	$ 43.55	$ 30.00
16501	External Cephalic Version for Breech Presentation, After 36 Weeks	0%	$ 129.85	$ 129.85	$ 60.00
16502	Attendance for treatment of Polyhydramnios, Unstable Lie, Multiple Pregnancy, Pregnancy Complicated by Diabetes or Anaemia, Threatened Premature Labour Treated by Bed Rest Only or Oral Medication,	10%	$ 39.55	$ 43.55	$ 20.00
16504	Attendance for the treatment of Habitual Miscarriage by Injection of Hormones Each Injection Up to a Maximum of 12 Injections	10%	$ 39.55	$ 43.55	$ 20.00
16505	Attendance for threatened Abortion, Threatened Miscarriage or Hyperemesis Gravidarum,	10%	$ 39.55	$ 43.55	$ 20.00
16508	Attendance for Pregnancy Complicated by Acute Intercurrent Infection, Intrauterine Growth Retardation, Threatened Premature Labour With Ruptured Membranes or Threatened Premature Labour Treated by Intravenous Therapy	10%	$ 39.55	$ 43.55	$ 20.00
16509	Attendance for the treatment of Preeclampsia, Eclampsia or Antepartum Haemorrhage	10%	$ 39.55	$ 43.55	$ 20.00
16511	Purse String Ligation of Cervix	0%	$ 203.20	No increase	$ 100.00
16512	Removal of Purse String Ligature of Cervix	0%	$ 58.65	No increase	$ 30.00
16514	Antenatal Cardiotocography in the Management of High Risk Pregnancy	0%	$ 33.85	No increase	$ 15.00
16515	Management of Vaginal Delivery As An Independent Procedure Where the Patient's Care Has Been Transferred by Another Medical Practitioner for Management of the Delivery	30%	$ 320.25	$ 416.35	$ 160.00
16518	Management of Labour, Incomplete, Where the Patient's Care Has Been Transferred to Another Medical Practitioner for Completion of the Delivery	30%	$ 320.25	$ 416.35	$ 160.00
16519	Management of Labour and Delivery by Any Means (Including Caesarean Section) Including Post-partum Care for 5 Days	30%	$ 493.15	$ 641.10	$ 300.00
16520	Caesarean Section and Post-operative Care for 7 Days Where the Patient's Care Has Been Transferred by Another Medical Practitioner	30%	$ 576.35	$ 749.30	$ 300.00
16522	Management of complicated birth	30%	$ 1,157.90	$ 1,505.30	$ 400.00

[63] These fees will be indexed along in line with the general fee increase applied across most MBS items.

[64] EMSN benefit caps will be indexed on 1 January 2010 by CPI in accordance with the method used for indexation of the EMSN threshold levels set out in section 10A of the *Health Insurance Act 1973*. For the EMSN, the reference quarter for CPI is the September quarter, as such the EMSN benefits caps to be implemented on 1 January 2010 will not be known until this value is available.

Table of Obstetrics items and EMSN benefit caps continued

Item Number	Description of service	Fee increase	Current Schedule Fee	New Schedule fee 1 January 2010 (excluding indexation)[65]	EMSN Cap (excluding indexation)[66]
16525	Management of Second Trimester Labour, With or Without Induction, for Intrauterine Fetal Death, Gross Fetal Abnormality or Life Threatening Maternal Disease	30%	$ 273.15	$ 355.10	$ 140.00
16564	Evacuation of Retained Products of Conception (Placenta, Membranes or Mole) As a Complication of Confinement, With or Without Curettage of the Uterus	0%	$ 201.40	No increase	$ 200.00
16567	Management of Postpartum Haemorrhage by Special Measures Such As Packing of Uterus	0%	$ 294.55	No increase	$ 200.00
16570	Vaginal Correction of Acute Inversion of the Uterus	0%	$ 384.35	No increase	$ 200.00
16571	Repair of Extensive Laceration or Lacerations of the Cervix	0%	$ 294.55	No increase	$ 200.00
16573	Repair of Third Degree Tear, Involving Anal Sphincter Muscles and Rectal Mucosa	0%	$ 240.05	No increase	$ 200.00
16590	Planning and Management of a Pregnancy That Has Progressed Beyond 20 Weeks.	150%	$ 119.75	$ 299.40	$ 200.00
16590 new	Planning and Management of a Pregnancy where the care of the patient will be transferred to another medical practitioner for the labour and delivery	10%	$ 119.75	$ 131.75	$ 100.00
16600	Amniocentesis	0%	$ 58.65	No increase	$ 30.00
16603	Chorionic Villus Sampling	0%	$ 112.60	No increase	$ 60.00
16606	Fetal Blood Sampling From Umbilical Cord or Fetus	0%	$ 224.70	No increase	$ 120.00
16609	Fetal Intravascular Blood Transfusion, Using Blood Already Collected, Including Neuromuscular Blockade, Amniocentesis and Fetal Blood Sampling.	0%	$ 458.20	No increase	$ 230.00
16618	Amniocentesis, Therapeutic	0%	$ 192.00	No increase	$ 95.00
16624	Drainage of Fetal Fluid Filled Cavity	0%	$ 276.30	No increase	$ 130.00
16627	Feto-amniotic Shunt, Insertion of, Into Fetal Fluid Filled Cavity, Including Neuromuscular Blockade and Amniocentesis	0%	$ 562.60	No increase	$ 280.00
16633	Procedure On Multiple Pregnancies Relating to Items 16606, 16609, 16612, 16615 and 16627	0%	$ 415.17	No increase	$ 210.00
16636	Procedure On Multiple Pregnancies Relating to Items 16600, 16603, 16618, 16621 and 16624	0%	$ 159.89	No increase	$ 80.00

[65] These fees will be indexed along in line with the general fee increase applied across most MBS items.
[66] EMSN benefit caps will be indexed on 1 January 2010 by CPI in accordance with the method used for indexation of the EMSN threshold levels set out in section 10A of the *Health Insurance Act 1973*. For the EMSN, the reference quarter for CPI is the September quarter, as such the EMSN benefits caps to be implemented on 1 January 2010 will not be known until this value is available.

Table of pregnancy ultrasound services and EMSN benefit caps

Item Number	Description of service	Fee increase	Current Medicare Schedule fee 1 Nov 2008	New Schedule fee 1 January 2010 (excluding indexation)	EMSN Cap (excluding indexation)[67]
55700	Pregnancy related scan - less than 12 weeks referred patient	0%	$ 60.00	No increase	$ 30.00
55703	Pregnancy related scan - less than 12 weeks non referred patient	0%	$ 35.00	No increase	$ 15.00
55704	Pregnancy related scan - 12 to 16 weeks referred patient	0%	$ 70.00	No increase	$ 35.00
55705	Pregnancy related scan - 12 to 16 weeks non referred patient	0%	$ 35.00	No increase	$ 15.00
55706	Pregnancy related scan - 17 to 22 weeks referred patient	0%	$ 100.00	No increase	$ 50.00
55707	Pregnancy related scan - rump length of 45 to 84mm referred patient	0%	$ 70.00	No increase	$ 35.00
55708	Pregnancy related scan - rump length of 45 to 84mm non referred patient	0%	$ 35.00	No increase	$ 15.00
55709	Pregnancy related scan - 17 to 22 weeks non referred patient	0%	$ 38.00	No increase	$ 20.00
55712	Pregnancy related scan - 17 to 22 weeks referred patient by obstetrician	0%	$ 115.00	No increase	$ 60.00
55715	Pregnancy related scan - 17 to 22 weeks non referred patient, performed by obstetrician	0%	$ 40.00	No increase	$ 20.00
55718	Pregnancy related scan - after 22 weeks referred patient	0%	$ 100.00	No increase	$ 50.00
55721	Pregnancy related scan - after 22 weeks referred patient by obstetrician	0%	$ 115.00	No increase	$ 60.00
55723	Pregnancy related scan - after 22 weeks non referred patient	0%	$ 38.00	No increase	$ 20.00
55725	Pregnancy related scan - after 22 weeks non referred patient, performed by obstetrician	0%	$ 40.00	No increase	$ 20.00
55729	Duplex scanning after 24th week	0%	$ 27.25	No increase	$ 15.00
55762	Pregnancy related scan - 17 to 22 weeks non referred patient which identifies multiple pregnancy	0%	$ 60.00	No increase	$ 30.00
55764	Pregnancy related scan - 17 to 22 weeks referred patient which identifies multiple pregnancy, performed by obstetrician	0%	$ 160.00	No increase	$ 80.00
55766	Pregnancy related scan - 17 to 22 weeks non referred patient which identifies multiple pregnancy, performed by obstetrician	0%	$ 65.00	No increase	$ 30.00
55768	Pregnancy related scan - after 22 weeks referred patient which confirms multiple pregnancy	0%	$ 150.00	No increase	$ 75.00

[67] These fees will be indexed along in line with the general fee increase applied across most MBS items.

[67] EMSN benefit caps will be indexed on 1 January 2010 by CPI in accordance with the method used for indexation of the EMSN threshold levels set out in section 10A of the *Health Insurance Act 1973*. For the EMSN, the reference quarter for CPI is the September quarter, as such the EMSN benefits caps to be implemented on 1 January 2010 will not be known until this value is available.

55770	Pregnancy related scan - after 22 weeks non referred patient which confirms multiple pregnancy	0%	$ 60.00	No increase	$ 30.00
55772	Pregnancy related scan - after 22 weeks referred patient by obstetrician which confirms multiple pregnancy	0%	$ 160.00	No increase	$ 80.00
55774	Pregnancy related scan - after 22 weeks referred patient which confirms multiple pregnancy performed by obstetrician	0%	$ 65.00	No increase	$ 35.00

Table of selected MBS services and EMSN benefit caps

Item number	Description	Current Medicare Schedule fee 1 Nov 2008	Change in Schedule fee (excluding indexation) [68]	EMSN Cap (excluding indexation)[69]
32500	Varicose vein treatment via injection of sclerosant	$ 101.45	No increase	$ 110.00
42702	Cataract surgery	$ 831.60	$409.60 (from November 2009)	$ 100.00
42740	Injection of a therapeutic substance into an eye	$ 277.85	No increase	$ 80.00
45560	Hair Transplantation	$ 437.60	No increase	$ 150.00

Table of Assisted Reproductive Technology Services and EMSN benefit caps

Item Number	Description	Current Medicare Schedule fee 1 Nov 2008	Change in Schedule fee (excluding indexation)[70]	EMSN Benefit Cap (excluding indexation)[71]
13200	ART services	$ 1,847.05	Fees could be amended during item restructure	$ 1,220.00
13203	Ovulation monitoring services	$ 461.80	-	$ 59.00
13206	ART services	$ 791.50	-	$ 382.00
13209	Planning and management of an ART cycle	$ 79.05	-	$ 540.00
13212	Oocyte retrieval	$ 336.45	-	$ 77.00
13215	Transfer of embryos	$ 105.55	-	$ 44.00
13218	Preparation and transfer of frozen or donated embryos	$ 791.50	-	$ 347.00
13221	Preparation of semen for ART or artificial insemination	$ 48.20	-	$ 25.00
13251	Intracytoplasmic sperm injection for ART treatment	$ 397.30	-	$ 55.00

[68] These fees will be indexed along in line with the general fee increase applied across most MBS items

[69] EMSN benefit caps will be indexed on 1 January 2010 by CPI in accordance with the method used for indexation of the EMSN threshold levels set out in section 10A of the *Health Insurance Act 1973*. For the EMSN, the reference quarter for CPI is the September quarter, as such the EMSN benefits caps to be implemented on 1 January 2010 will not be known until this value is available.

[70] The items for ART services will be restructured in negotiation with the ART profession. The final MBS schedule fees and the EMSN benefit caps will be negotiated within the funding allocation.

[71] As noted above, the items for ART services will be restructured in negotiation with the ART procession.

Appendix B – Items found to have high out of pocket costs in the EMSN Review Report 2009

For the items in the below table it was found that for every EMSN dollar spent on that service, 78 cents went to providers' higher fees and 22 cents went to reducing patient out-of-pocket costs.

High Average OOP cost ≥ $50) (after EMSN benefits)	32500	VARICOSE VEIN TREATMENT - using injection of sclerosant (a chemical which causes the vein to close) and compression of the veins, where the vein is 2.5mm or greater in diameter, including associated consultation - 1 or both legs
	42740	OPTHALMOLOGY- injection of a therapeutic substances into the eye
	42702	OPTHALMOLOGY- removal of lens and insertion of an artificial lens for the treatment of cataracts
	55706	DIAGNOSTIC IMAGING - ultrasound of the pelvis/abdomen for pregnancy related or pregnancy complication, fetal development and anatomy (17-22 weeks)
	15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or off axis fields, or several joined fields
	13203	ASSISTED REPRODUCTIVE TECHNOLOGY - ovulation monitoring services or superovulated treatment cycles of less than 9 days duration and artificial insemination - including quantitative estimation of hormones and ultrasound examinations
	42740	OPTHALMOLOGY- injection of a therapeutic substances into the eye
	30653	OPERATION - Circumcision of a male under 6 months of age
	32500	VARICOSE VEIN TREATMENT - using injection of sclerosant (a chemical which causes the vein to close) and compression of the veins, where the vein is 2.5mm or greater in diameter, including associated consultation - 1 or both legs
	42702	OPTHALMOLOGY- removal of lens and insertion of an artificial lens for the treatment of cataracts
	13209	ASSISTED REPRODUCTIVE TECHNOLOGY planning and management of an ART treatment cycle
	13218	ASSISTED REPRODUCTIVE TECHNOLOGY - preparation and transfer of frozen or donated embryos the female by any means and including all treatment and counselling services but excluding artificial insemination
	45026	OPERATION - laser resurfacing of the face or neck- more than 1 area
	35321	OPERATIONS - Blood vessel catherisation to administer substances to block blood vessels or to stop bleeding
	13200	ASSISTED REPRODUCTIVE TECHNOLOGY- various ART services such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services

Appendix C – Further information about the methodology of the EMSN Review and the concerns of the Australian Medical Association

CHERE consulted with Medicare Australia, the AMA and representatives from a number of professional groups as part of the review of the EMSN. When giving evidence at the Senate Inquiry, the AMA expressed concerns that the profession were not able to provide comments on the EMSN Review report prior to its release, they also noted that CHERE had advised that the EMSN Review report would not be released until at least July 2009.

As the report was required to be tabled in Parliament, it was embargoed and could not be publicly released before this occurred. CHERE provided the AMA with a summary of the issues discussed at their meeting and the AMA agreed that this was an accurate representation of the discussion. This summary was included in the EMSN Review report as an attachment and posted on the Department's website on the day that the report was tabled in Parliament. The Department has checked with CHERE whether there was any mention at this meeting of the timeframe of July for completion of the report. CHERE has confirmed that a July report date was not advised. Their contract required the report to be complete by early April 2009.

The EMSN Review report was tabled in Parliament and made available on the Department's website on 12 May 2009, the same day that the Government announced changes to the EMSN.

CHERE was also provided with de-identified correspondence received by the Department to inform its understanding of the operational issues that affected patients.

It is important to note that the data that was analysed by CHERE was based on date of service information. As many patients do not submit their Medicare claims immediately, it is necessary to wait at least 6 to 12 months after the period in question to ensure the data is accurate. This means that data from 2008 was not included in the review and the results do not take into account the continued large increases in the fees charged by some doctors in 2008 and 2009.

The AMA has also questioned the use of CPI in the EMSN Review report, arguing that CPI is used as a benchmark implying that any increases in fees above CPI is excessive. However, CHERE used CPI to allow the fees charged data to be presented and analysed in 'real terms' that is, with the impact of inflation removed. This is standard practice when analysing data. CPI was not used as a benchmark for assessing whether the increases in the fees charged were reasonable as asserted by the AMA. The analysis did not examine whether the general increase in fees charged was acceptable or 'excessive' but rather whether the fees increased as a result of the EMSN.

Fee increases were compared between types of items in and out-of-hospital, to determine whether there were any differences in the rate of increase in the fees charged across the MBS. Areas were only identified where the rate of growth in fees charged was higher than other MBS items not higher than CPI. As set out in section 3.4, CHERE did not find that fees had increased significantly in many areas of the MBS.

Appendix D – Impact of MBS rebate increase and EMSN benefit caps for obstetrics services.

Example 1. Increases in the MBS Schedule fees for obstetric services
This example shows the impact on patients of increases in the MBS schedule fees for a typical bundle of obstetric services.

Table 1 outlines the increase in MBS Schedule fees and the MBS Schedule rebates for selected items relating to obstetrics.

Table 1: MBS Schedule fees for selected items

Service	MBS Item	Existing fee structure		New fee structure			
		MBS fee	MBS rebate	Increase in MBS	MBS fee	MBS rebate	EMSN Cap
GP confirmation of pregnancy	23	33.55	33.55	-	33.55	33.55	None
Initial specialist attendance	104 (16401)^	79.05	67.20	-	79.05	67.20	50.00
Planning & Management of Pregnancy	16590 (16591)^^	119.75	101.80	150%	299.40	254.50	200.00
Antenatal attendance	16500	39.55	33.65	10%	43.55	37.05	30.00
Management of labour & birth	16519	493.15	369.90 *	30%	641.10	480.85 *	300.00

* Assumed in-hospital, so 75% Medicare rebate applied.
^ New Item: Pregnancy or obstetrics related initial specialist attendance
^^ New Item: Planning and management of a pregnancy where the clear intention is for the doctor to attend and fully manage the birth

A typical bundle of services used by women who elect to see a private obstetrician for the management of their pregnancy would include a number of antenatal appointments, various ultrasounds and pathology tests. The following looks at the way the changes in the MBS will affect the rebates for a typical set of medical appointments, excluding ultrasounds and pathology.

Typical bundle of obstetric services:

			Existing rebate	New rebate
1	x	GP appointment	$ 33.55	$ 33.55
1	x	Initial specialist attendance	$ 67.20	$ 67.20
1	x	Planning & management of pregnancy	$ 101.80	$ 254.50
10	x	Antenatal appointments, and	$ 336.50	$ 370.20
1	x	Management of labour & birth	$ 369.90	$ 480.85
			$ 908.95*	**$ 1,206.30***

*** not including EMSN benefits**

Under the existing fee structure the Medicare rebate for this bundle of services would be $908.95. With the increase in the schedule fee for selected items, patients will be eligible for $1,206.30 in rebates for the same bundle of services, an increase of $297.35 in Medicare rebates.

Example 2 Increase in the MBS Schedule fee combined with capping of EMSN benefits
This example shows how the increase in the MBS Schedule fee, combined with the capping of EMSN benefits, will impact on out of pocket (OOP) costs of patients for MBS item 16590, Planning and Management of Pregnancy. The EMSN benefit for this item is to be capped at $200.00.

All the following scenarios assume the fee charged for this item is $1,000

Scenario A – Patient needs to spend $555.70 to qualify for the EMSN
In scenario A, the patient needs to accumulate an additional $555.70 in OOP costs to qualify for the EMSN. For people eligible for the lower threshold of the EMSN (Commonwealth concession card holders and FTB(A) recipients), this scenario assumes that they have had no OOP costs in this calendar year. For people on the higher EMSN threshold, they have accumulated $555.90 in OOP costs and have to accumulate $555.70 to reach the $1,111.60 EMSN threshold.

In this scenario, only OOP costs above $555.70 are eligible for the EMSN benefit.

This table illustrates patient OOP costs for Item 16590 Planning and Management of Pregnancy, using the existing MBS Schedule fee and rebate, without a capped EMSN benefit:

OOP costs required to meet EMSN threshold	Item 16590	MBS Schedule Fee	Standard MBS rebate	OOP Costs before EMSN benefit	EMSN benefit	Final OOP
$ 555.70	$ 1,000	$ 119.75	$ 101.80	$ 898.20	$ 274	$ 624.20

This table illustrates patient OOP costs for Item 16590 Planning and Management of Pregnancy, using the new MBS Schedule fee and rebate, with capped EMSN benefits:

OOP costs required to meet EMSN threshold	Provider Fee	MBS Schedule Fee	Standard MBS rebate	OOP Costs before EMSN benefit	EMSN benefit	Final OOP
$ 555.70	$ 1,000	$ 299.40	$ 254.50	$ 745.50	$ 161.35	$ 584.15

In this scenario, where a patient needs to spend $555.70 to qualify for the EMSN, and is charged $1,000 for Medicare Item 16590 Planning and Management of Pregnancy, they will $40.05 better off under the newly structured MBS Schedule fee and the capped EMSN rebate.

Scenario B – Patient needs to spend $1,111.60 to qualify for the EMSN
In scenario B, the patient needs to accumulate an additional $1,111.60 in OOP costs to qualify for the EMSN. For people on the higher EMSN threshold, this assumes that they have had no OOP costs this calendar year. This scenario is not applicable for people eligible for the lower threshold of the EMSN (Commonwealth concession card holders and FTB(A) recipients) as they qualify for the EMSN with $555.70 in OOP costs.

This table illustrates patient OOP costs for Item 16590 Planning and Management of Pregnancy, using the existing MBS Schedule fee and rebate, without a capped EMSN benefit:

OOP costs required to meet EMSN threshold	Provider Fee	MBS Schedule Fee	Standard MBS rebate	OOP Costs before EMSN benefit	EMSN benefit	Final OOP
$ 1,111.60	$ 1,000	$ 119.75	$ 101.80	$ 898.20	$ 0	$ 898.20

This table illustrates patient OOP costs for Item 16590 Planning and Management of Pregnancy, using the new MBS Schedule fee and rebate, with capped EMSN benefits:

OOP costs required to meet EMSN threshold	Provider Fee	MBS Schedule Fee	Standard MBS rebate	OOP Costs before EMSN benefit	EMSN benefit	Final OOP
$ 1,111.60	$ 1,000	$ 299.40	$ 254.50	$ 745.50	$ 0	$ 745.50

In this scenario, where a patient needs to spend $1,111.60 to qualify for the EMSN, and is charged $1,000 for Medicare Item 16590 Planning and Management of Pregnancy, they will $152.70 better off under the newly structured MBS Schedule fee and the capped EMSN rebate.

Scenario C – Patient has already qualified for the EMSN

In scenario C, the patient has already qualified for the EMSN. This means that they have already had $1,111.60 in OOP costs that calendar year, or $555.70 in OOP costs for Commonwealth concession card holders and FTB(A) families (these are the thresholds that apply in the 2009 calendar year, and are indexed by CPI on 1 January each year).

In this scenario, all OOP costs are eligible for the EMSN benefit.

This table illustrates patient OOP costs for Item 16590 Planning and Management of Pregnancy, using the existing MBS Schedule fee and rebate, without a capped EMSN benefit:

OOP costs required to meet EMSN threshold	Item 16590	MBS Schedule Fee	Standard MBS rebate	OOP Costs before EMSN benefit	EMSN benefit	Final OOP
$ 0	$ 1,000	$ 119.75	$ 101.80	$ 898.20	$ 718.56	$ 179.64

This table illustrates patient OOP costs for Item 16590 Planning and Management of Pregnancy, using the new MBS Schedule fee and rebate, with capped EMSN benefits:

OOP costs required to meet EMSN threshold	Item 16590	MBS Schedule Fee	Standard MBS rebate	OOP Costs before EMSN benefit	EMSN benefit	Final OOP
$ 0	$ 1,000	$ 299.40	$ 254.50	$ 745.50	$ 200	$ 545.50

In this scenario, where a patient has already qualified for the EMSN, and is charged $1,000 for Medicare Item 16590 Planning and Management of Pregnancy, they will have $365.86 in additional out of pocket costs for this item under the newly structured MBS Schedule fee and the capped EMSN rebate.

Appendix E – Explanation of ART cycles

ART can involve many different medical procedures, using differing paths to conception. A cycle of ART is therefore not the same for every woman. There are four main types of cycles (the below combinations can be called one cycle of ART.):

1. *Stimulated cycle with harvest and implantation of a fresh embryo:*
   - Giving hormone drugs to stimulate ovaries to produce ova or eggs (also known as an oocytes);
   - Harvesting the fresh eggs;
   - Checking the health and vigour of the eggs under a microscope;
   - Putting sperm with the eggs in the laboratory to form an embryo(IVF);
   - Examining the newly fertilised eggs under a microscope to choose the healthiest group of dividing cells (known as a zygote);
   - Freezing and storing embryos that are not required immediately for use;
   - Implanting a fresh embryo into the mother's womb; and
   - Confirming the pregnancy.

2. *Non-stimulated cycle with harvest and implantation of a fresh embryo:*
   - Tracking the development of ova or eggs in the ovaries, in some cases using clomiphene to stimulate ovulation;
   - Harvesting the fresh eggs;
   - Checking the health and vigour of the eggs under a microscope;
   - Putting male sperm with the eggs in the laboratory to form an embryo;
   - Examining the newly fertilised eggs under a microscope to choose the healthiest group of dividing cells (known as a zygote);
   - Implanting a fresh embryo into the mother's womb; and
   - Confirming the pregnancy.

3. *Stimulated cycle with artificial insemination and natural implantation*:
   - Giving hormone drugs to stimulate her ovaries to produce ova or eggs;
   - Monitoring the release of the eggs;
   - Introducing sperm at the best time to achieve fertilisation; and
   - Confirming a pregnancy.

4. *Unstimulated cycle with implantation of a frozen embryo*:
   - Monitoring the womb to implant the embryos at the optimal time for implanting;
   - Thawing and examining the frozen embryo for health an vigour prior to implantation;
   - Implanting a embryo into the mother's womb; and
   - Confirming the pregnancy.

At the Senate hearings, some stakeholders commented that the notion of capping EMSN benefits for ART services is a sensible approach to managing the financial risk associated with funding high cost procedures. One stakeholder stated that if it could be shown that patients charged at the current median fee for an ART cycle would not be worse off under these changes then he would consider supporting the proposal. The example set out in Appendix F shows that patients will not be worse off under this measure, if ART doctors do not grossly increase their fees.

Appendix F – Impact of the measure on ART patients at the median fee

This example shows that ART patients charged at the median fee will be no worse off as a result of the measure.

Hypothetical scenario involving a stimulated cycle with harvest and implantation of a fresh embryo:

Item	Schedule Fee (Nov 2008)	Standard MBS Benefit (Nov 2008)**	EMSN Cap (excl index)	Total MBS rebate available (including EMSN)
13209 – planning the cycle	$79.05	$67.20	$540.00	$607.20
13200 – use of drugs to stimulate eggs	$1,847.05	$1,778.95	$1,220.00	$2,998.95
13212 – harvesting eggs - *	$336.45	$252.35	*	$252.35
13221 – preparation of semen	$48.20	$41.00	$25.00	$66.00
13251 – intracytoplasmic sperm injection	$397.30	$337.75	$55.00	$392.75
13215 – transfer of embryo - *	$105.55	$79.20	*	$79.20
Total	**$2,813.60**	**$2,556.45**	**$1,840.00**	**$4,396.45**

* Items 13212 and 13215 are generally performed on an admitted patients so no EMSN benefit is payable. Additional charges will apply for theatre, accommodation and anaesthetists.
** Standard MBS benefit paid to patients, excluding any benefits paid under the EMSN. For in-hospital services, the MBS rebate is 75% of the MBS Schedule Fee. For out-of-hospital services, the rebate is 85% of the MBS Schedule Fee. Maximum patient gap and standard rounding rules also apply.

In this stimulated cycle scenario the maximum benefit level (EMSN cap and Medicare benefit) will be $4,396.45. The minimum charge to reach this level for a patient to reach this benefit level, if a patient had already reached the EMSN threshold, is $5,155. If the patient has not reached the EMSN threshold, this charge would be greater. This is above what the median patient is currently charged for this scenario.

That is, only if the patient is charged more than $5,155 for this package of MBS services will they receive the full amount of MBS benefits (including EMSN benefits) payable. If the patient also has other MBS services such as additional consultations with their specialist, they will also receive the rebate for these services, and be eligible to receive up to the maximum EMSN benefit cap for that item.

The scenario above assumes that the person has already qualified for the safety net. If they have not, then they will not 'reach the cap' until they are charged significantly more for this package of MBS items outlined above. If the person faces the higher threshold and has no out of pocket costs (that is, they still have to spend more than $1111.60 to qualify for benefits under the EMSN), they would need to be charged at least $6,266 before they have received the maximum MBS benefits (including EMSN benefits) that they will be entitled to as a result of the introduction of capping.

Current patient out of pocket costs
The actual out-of-pocket cost for a cycle of ART for a patient being charged the figures set out in the hypothetical example varies between patients.

In addition to the MBS items listed above, patients are also billed for other costs such as theatre fees, accommodation and anaesthetics.

The total out-of-pocket costs for a treatment cycle, both now and in the future, depends on the person's private health insurance and whether or not they have already qualified for the safety net.

Explanation
In the scenario set out above, a patient would need to be charged more than $5,155 for the package of ART items that constitutes a typical ART cycle.

This is above the median charge for this group of items.

The maximum amount of EMSN benefits that the patient will still be entitled to is $1,840, which is more than the majority of patients receive for this package of items. The MBS rebates available (including the EMSN benefits) is $4,396.45, which is more than most patients having a typical ART cycle receive.

Should the patient have more Medicare funded services, they will be eligible for additional MBS rebates, and a higher level of EMSN cap. There is no cap on the total amount of EMSN benefits available to a patient.

The information provided as part of the introduction of capping is that a person charged at around $6,000 will not be worse off. A fee of $6,000 includes theatre, accommodation and anaesthetics fees, as well as for specialist consultations. Theatre and accommodation fees are covered by PHI, rather than by Medicare, and MBS funding is still provided for anaesthetics and specialist consultations. Even where a patient is charged in the order of $6,500, these fees will be at least $1,000 per cycle, meaning that the patient who is charged less than $5,500 for the items specified in the table above, should not be paying more than they currently do. As part of an overall package of ART treatment, further MBS items for the extraction of semen may apply. These charges are billed to the male, but are part of the total fee charged by the clinic. Therefore while the fee charged for the entirety of the cycle may be more than $6,000, the patient still need not be worse off as a result of the introduction of capping.

Appendix G – Statistics relating to Cataract Surgery (item 42702)

Data notes:
1. Date is based on the date of processing of the claim by Medicare Australia, not the date at which the service actually took place.
2. Includes all services, including bulk billed services.
3. Extracted from Medicare data.

	Total out of hospital services		**Total in-hospital services**		**Total services**		**Out-of-hospital %**
Year 1998	**2,455**		**66,793**		69,248		3.5%
Year 1999	**2,690**		**67,919**		70,609		3.8%
Year 2000	**2,357**		**73,910**		76,267		3.1%
Year 2001	**2,704**		**81,075**		83,779		3.2%
Year 2002	**2,944**		**86,292**		89,236		3.3%
Year 2003	**3,388**		**89,899**		93,287		3.6%
Year 2004	**4,038**		**96,562**		100,600		4.0%
Year 2005	**3,526**		**103,949**		107,475		3.3%
Year 2006	**2,658**		**108,983**		111,641		2.4%
Year 2007	**4,516**		**113,969**		118,485		3.8%
Year 2008	**5,142**		**123,441**		128,583		4.0%

Geographical distribution of services and benefits paid for item 42702 cataract surgery, calendar year 2008

	Total		**In-hospital services**		**Out-of-hospital services**		**Proportion of total for geographical area**	
	Number of services	Benefits Paid	Number of services	Benefits Paid	Number of services	Benefits Paid	Proportion of total services paid	Proportion of total benefits paid
Total	128,583	$80,380,959	123,441	$75,080,453	5,142	$5,300,505		
Capital City	78,886	$49,500,370	75,472	$45,887,713	3,414	$3,612,657	61%	62%
Other Metro Centre	11,647	$7,191,278	10,869	$6,604,608	778	$586,670	9%	9%
Large Rural Centre	8,930	$5,528,855	8,837	$5,383,511	93	$ 145,344	7%	7%
Small Rural Centre	9,798	$6,161,398	9,554	$5,817,628	244	$ 343,770	8%	8%
Other Rural	17,372	$10,790,032	16,933	$10,307,562	439	$482,470	14%	13%
Remote Centre	707	$441,018	637	$388,530	70	$52,488	1%	1%
Other Remote Area	1,243	$768,008	1,139	$690,902	104	$77,107	1%	1%