

## EXPLANATORY STATEMENT

### *Health Insurance Act 1973*

#### *Health Insurance Legislation Amendment (2022 Measures No. 1) Determination 2022*

Subsection 3C(1) of the *Health Insurance Act 1973* (the Act) provides that the Minister may, by legislative instrument, determine that a health service not specified in an item in the general medical services table (the Table) shall, in specified circumstances and for specified statutory provisions, be treated as if it were specified in the Table.

The Table is set out in the regulations made under subsection 4(1) of the Act. The most recent version of the regulations is the *Health Insurance (General Medical Services Table) Regulations 2021*.

This instrument relies on subsection 33(3) of the *Acts Interpretation Act 1901* (AIA). Subsection 33(3) of the AIA provides that where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend, or vary any such instrument.

Subsection 12(1A) of the *Legislation Act 2003* provides a registered legislative instrument may have a commencement date prior to the date of registration (retrospective commencement).

Subsection 12(2) provides this is subject to the conditions it does not disadvantage a person (other than the Commonwealth) or impose a liability on a person (other than the Commonwealth). Subsection 12(4) of the *Legislation Act 2003* provides the effect of subsection (2) in relation to an instrument is subject to any contrary provision in an Act.

Subsection 3C(2) of the Act expressly excludes subsection 12(2) of the *Legislation Act 2003* from applying to determinations made under section 3C(1) of the Act. However, this instrument will not impose a liability or disadvantage a person other than the Commonwealth, consistent with the intent of *Legislation Act 2003*.

### **Purpose**

Since 13 March 2020, the Australian Government has been providing temporary access to Medicare benefits for certain medical services to protect Australians during the coronavirus (COVID-19) pandemic.

On 16 January 2022, the Australian Government announced, in response to the recent surge in Omicron COVID-19 cases, it will invest an additional \$24 million to introduce critical changes to the Medicare Benefits Schedule (MBS) to support their continued response to COVID-19. The changes include temporarily reinstating 75 telehealth and phone services to enable practitioners to support their patients during the current increase in Omicron COVID-19 cases.

The purpose of Schedule 1 of the *Health Insurance Legislation Amendment (2022 Measures No. 1) Determination 2022* (the Amendment Determination) is to give effect to these temporary telehealth and phone items from 1 January 2022 to 30 June 2022. The items include:

- reinstate 40 temporary items for specialist telehealth and phone services performed by the admitting medical practitioner or admitting dental practitioner for private patients admitted to hospital. These services can be rendered by practitioners who are in isolation or quarantine because of a State or Territory public health order. The services covered by the 40 new telehealth and phone items will not be considered hospital treatment for the purposes of the *Private Health Insurance Act 2007* by rules made under that Act. This means that the items will have a Medicare benefit of 85% of the schedule fee and will not attract a private health insurance benefit; and
- reinstate 33 temporary items for initial phone attendances for specialists and consultant physicians; and
- reinstate 2 GP phone attendances lasting at least 20 minutes if the service is performed by the patient's usual medical practitioner.

The purpose of Schedule 2 of the Amendment Determination is to make a consequential change to the vaccine assessment items to update the co-claim limitation. The co-claim limitation, which prevents the vaccine assessment items from being co-claimed with the bulk-billing incentive items in the Table, will be updated to include the new bulk-billing incentives that were listed on 1 January 2022.

### **Consultation**

Considering the nature of the instrument and due to the short timeframe in drafting the Amendment Determination, it was not reasonably practicable to undertake broader consultation on it.

However health stakeholders, including the Australian Medical Association and the Royal Australian College of General Practitioners, have welcomed the Government's decision to provide greater support and flexibility to manage COVID-19 positive patients in the community.

Details of the Amendment Determination are set out in the [Attachment](#).

The Amendment Determination commences immediately after registration. Schedule 1 of this instrument is taken to have commenced on 1 January 2022. Schedule 2 of this instrument will commence the day after registration.

The Amendment Determination is a legislative instrument for the purposes of the *Legislation Act 2003*.

**Authority:** Subsection 3C(1) of the  
*Health Insurance Act 1973*

**Details of the *Health Insurance Legislation Amendment (2022 Measures No. 1) Determination 2022***

Section 1 – Name

Section 1 provides for the instrument to be referred to as the *Health Insurance Legislation Amendment (2022 Measures No. 1) Determination 2022* (the Amendment Determination).

Section 2 – Commencement

Section 2 provides that Sections 1 to 4 of the Amendment Determination commence immediately after registration. Schedule 1 is taken to have commenced retrospectively from 1 January 2022. Schedule 2 of the Amendment Determination commences the day after registration.

Section 3 – Authority

Section 3 provides that the Amendment Determination is made under subsection 3C(1) of the *Health Insurance Act 1973*.

Section 4 – Schedules

Section 4 provides that each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

Schedule 1 – Amendments to remote service options

Schedule 1 makes amendments to the *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2022* (Principal Remote Service Determination).

**Amendment item 1 – section 4**

Item 1 will amend the cessation provision to automatically revoke the specialist in-hospital services items (Schedule 6), the specialist initial and complex phone services items (Schedule 7) and the COVID-19 impacted GP phone services (Schedule 8) from the end of 30 June 2022. There is no change to the date of the cessation for the items in Schedule 5 of the Principal Remote Service Determination.

**Amendment item 2 – subsection 5(1)**

Item 2 inserts definitions for *admitting dental practitioner* and *admitting medical practitioner* in subsection 5(1). *Admitting medical practitioner* means the medical practitioner responsible for the patient's treatment at the time the patient is admitted to hospital and *admitting dental practitioner* means the dental practitioner responsible for the patient's treatment at the time the patient is admitted to hospital. These definitions are used to apply a requirement for the specialist in-hospital services items in Schedule 6.

**Amendment item 3 – subsection 5(1), definition of *psychiatrist assessment and management plan***

Item 3 omits and substitutes the definition of **psychiatrist assessment and management plan** to include the consultant psychiatrist phone services 92475 which is listed by this instrument. This item is equivalent to telehealth item 92435 which is currently included in the definition in the Principal Remote Service Determination. A psychiatrist assessment and management plan enables patients to access a range of mental health treatment services performed by allied health providers.

**Amendment item 4 – After subsection 7(1)**

Item 4 inserts subsection (1A) to exclude items in Schedule 6 from having application to the general rule that the services cannot be provided to admitted patients, as defined in section 5 of the Principal Remote Service Determination. This instrument will list Schedule 6 which contains items that can only be performed on admitted patients.

**Amendment item 5 – subsection 7(4)**

Item 5 omits and substitutes the specified text to capture the new group psychotherapy items (92495 to 92497). Including these items in subsection 7(4) will exclude them from the general rule in subsection 7(3) that an item in the Principal Remote Service Determination only applies to a service that is an attendance by a single health professional on a single person.

**Amendment item 6 – Schedule 2 (item 92624, cell at column 2)**

Item 6 amends the descriptor of item 92624 to capture the new geriatrician phone management plan service (92628), which is equivalent to the telehealth item 92623. These items are required to be specified in the descriptor of item 92624 to enable patients to access a review of their geriatrician management plan.

**Amendment item 7 – Schedule 3 (clauses 3.1.2, 3.1.3 and 3.1.5)**

In the Principal Remote Service Determination:

- Clause 3.1.2 includes conditions on referrals by psychiatrists and paediatricians for patients accessing a pervasive developmental disorder service in Subgroups 15 and 16 of Group M18.
- Clause 3.1.3 includes conditions on referrals by specialists, consultant physicians and general practitioners for patients accessing a disability service in Subgroups 15 and 16 of Group M18.
- Clause 3.1.5 includes conditions on referrals by specialists, consultant physicians and general practitioners for patients accessing a psychological therapy and focussed psychological strategies therapy health service items 91166 to 91176 and 91181 to 91188.

The purpose of amendment item 7 is to repeal and substitute the clauses to include the initial phone items that are equivalent to telehealth or face-to-face items referenced in those clauses in the Principal Remote Service Determination. This will enable patients to be referred for the specified pervasive developmental disorder, disability service or psychological therapy and focussed psychological strategies therapy health services under the new phone items.

**Amendment item 8 – Schedule 3 (subclause 3.1.7(6))**

In the Principal Remote Service Determination, subclause 3.1.7(6) includes conditions on referrals for patients to access eating disorder treatment services in Subgroups 19 to 22 of Group M18. The purpose of amendment item 8 is to repeal and substitute the subclause to include the

initial and complex phone items that are equivalent to telehealth or face-to-face items referenced in those clauses in the Principal Remote Service Determination. This will enable patients to be referred for the eating disorder treatment services under the new phone items.

### **Amendment item 9 – at the end of the instrument**

Item 6 inserts three new Schedules (6, 7 and 8) to list in-hospital services items (Schedule 6), the specialist initial phone services items (Schedule 7) and the COVID-19 impacted GP phone services (Schedule 8).

#### Schedule 6 – Specialist in-hospital services

Schedule 6 lists 40 temporary items for specialist telehealth and phone services provided to private patients who are being treated in a public or private hospital, including 36 specialist, consultant physician and consultant psychiatrist items that will be treated as if they are included in Group A40 of the general medical services table (the Table) and four new items for dental practitioners in the practice of oral and maxillofacial surgery that will be treated as if they are included in Group O1 of the Table.

The items can be claimed if all of the following apply:

- the patient who receives the service is admitted to hospital;
- the medical or dental practitioner who performs the service is in isolation or quarantine because of a State or Territory public health order;
- the medical or dental practitioner was responsible for the patient's treatment at the time the patient was admitted to hospital.

The *Private Health Insurance (Health Insurance Business) Rules 2018* will be amended to specify that the treatments covered by the new items are not hospital treatment for the purposes of the *Private Health Insurance Act 2007*. As services that attract Medicare benefit, the services will also not be general treatment.

As services that are not hospital treatment or hospital-substitute treatment, the Medicare benefit for these items will be paid at 85% of the schedule fee.

#### Schedule 7 - Specialists initial Phone Services

Schedule 7 lists 33 temporary phone services for initial COVID-19 specialist services for initial, more complex telehealth services for specialists, consultant physicians, psychiatrists, paediatricians, geriatricians, public health physicians, neurosurgeons and anaesthetists.

#### Schedule 8 – COVID-19 impacted GP phone services

Schedule 8 lists 2 temporary items for GPs (92746) or other medical practitioners in general practice (92747) to perform a phone attendance lasting at least 20 minutes. These services are subject to the usual medical practitioner requirement, per subsection 7(5) of the Principal Remote Service Determination.

#### Schedule 2 – Amendments to vaccine suitability service

This Schedule will amend the *Health Insurance (Section 3C General Medical Services – General Practice Attendance for Assessing Patient Suitability for a COVID-19 Vaccine) Determination 2021* to apply a co-claim restriction on the vaccine assessment items and the bulk-billing incentive items in the general medical services table. This amendment is required to

capture the new bulk-billing incentive items, which were listed on 1 January 2022 but were inadvertently omitted from being included in this limitation.

## Statement of Compatibility with Human Rights

*Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011*

*Health Insurance Legislation Amendment (2022 Measures No. 1) Determination 2022*

This instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

### Overview of the Determination

Since 13 March 2020, the Australian Government has been providing temporary access to medicare benefits for certain medical services to protect Australians during the coronavirus (COVID-19) pandemic.

On 16 January 2022, the Australian Government announced, in response to the recent surge in Omicron COVID-19 cases, it will invest an additional \$24 million to introduce critical changes to the Medicare Benefits Schedule (MBS) to support their continued response to COVID-19. The changes include temporarily reinstating 75 telehealth and phone services to enable practitioners to support their patients during the current increase in Omicron COVID-19 cases.

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The purpose of Schedule 2 of the Amendment Determination is to make a consequential change to the vaccine assessment items to update the co-claim limitation. The co-claim limitation, which prevents the vaccine assessment items from being co-claimed with the bulk-billing incentive items in the Table, will be updated to include the new bulk-billing incentives that were listed on 1 January 2022. Schedule 2 will have effect the day after registration of the Amendment Determination.

### Human rights implications

This instrument engages Articles 9 and 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), specifically the rights to health and social security.

#### *The Right to Health*

The right to the enjoyment of the highest attainable standard of physical and mental health is contained in Article 12(1) of the ICESCR. The UN Committee on Economic Social and Cultural Rights (the Committee) has stated that the right to health is not a right for each individual to be

healthy, but is a right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

The Committee reports that the *'highest attainable standard of health'* takes into account the country's available resources. This right may be understood as a right of access to a variety of public health and health care facilities, goods, services, programs, and conditions necessary for the realisation of the highest attainable standard of health.

#### *The Right to Social Security*

The right to social security is contained in Article 9 of the ICESCR. It requires that a country must, within its maximum available resources, ensure access to a social security scheme that provides a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care. Countries are obliged to demonstrate that every effort has been made to use all resources that are at their disposal in an effort to satisfy, as a matter of priority, this minimum obligation.

The Committee reports that there is a strong presumption that retrogressive measures taken in relation to the right to social security are prohibited under ICESCR. In this context, a retrogressive measure would be one taken without adequate justification that had the effect of reducing existing levels of social security benefits, or of denying benefits to persons or groups previously entitled to them. However, it is legitimate for a Government to re-direct its limited resources in ways that it considers to be more effective at meeting the general health needs of all society, particularly the needs of the more disadvantaged members of society.

#### *The right of equality and non-discrimination*

The rights of equality and non-discrimination are contained in articles 2, 16 and 26 of the International Covenant on Civil and Political Rights (ICCPR). Article 26 of the ICCPR requires that all persons are equal before the law, are entitled without any discrimination to the equal protection of the law and in this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

#### Analysis

This instrument maintains the rights to health and social security and the right of equality and non-discrimination by providing patients and medical practitioners with an increased range of remote service options on a temporary basis. This will enable patients to continue to receive access to timely and quality medical care and provide practitioners with options in determining the appropriate means for patients to receive medical care. Any Medicare-eligible person who meets the requirements of the items and receives a service is eligible for a Medicare benefit. This provides universal access to health care.

#### **Conclusion**

This instrument is compatible with human rights as it maintains the right to health, the right to social security and the right of equality and non-discrimination.

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