Medicare Safety Net Arrangements – 1 January 2018

Last updated: 19/12/2018

This fact sheet provides information on the Original Medicare Safety Net and the Extended Medicare Safety Net.

What is the Original Medicare Safety Net?

The Original Medicare Safety Net (OMSN) works in conjunction with the Extended Medicare Safety Net (EMSN). Under the OMSN, once the annual threshold is reached, Medicare benefits increase to 100 per cent of the Medicare Benefits Schedule (MBS) Fee for all out-of-hospital services for the rest of the calendar year. Only the 'gap amount' counts towards the OMSN threshold. The 'gap amount' is the difference between the Medicare rebate and the MBS Fee. The OMSN is calculated prior to the EMSN.

The OMSN threshold is indexed by the Consumer Price Index (CPI) on 1 January each year. From 1 January 2019 the annual OMSN threshold is **$470.00**.

What is the Extended Medicare Safety Net?

The EMSN provides an increased rebate for Australian families and singles who incur out-of-pocket costs for Medicare eligible out-of-hospital services. Once the relevant annual threshold of out-of-pocket costs has been met, Medicare will pay up to 80 per cent of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, there is an upper limit on the amount of benefit that can be paid under the EMSN for a small number of Medicare services.

There are two thresholds for the EMSN. These thresholds are indexed by the CPI on 1 January each year. From 1 January 2019 the annual EMSN thresholds are:

- **$680.70** for Commonwealth concession cardholders, including those with a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Card, and people who receive Family Tax Benefit (Part A); and
- **$2,133.00** for all other singles and families.

Couples and families should contact the Department of Human Services – Medicare to register their family members as part of a safety net eligible family. Registering as a family allows eligible out-of-pocket costs for each individual family member to count towards the family's EMSN threshold. Couples and families need to register even if all family members are listed on the Medicare card. Registration is only required once, unless family members change, for example, if a student child is no longer studying full time or you have a newborn baby.

What are out-of-hospital services?

Out-of-hospital services include GP and specialist attendances, services provided in private clinics and private emergency departments, and many pathology and diagnostic imaging services. However, many day surgery facilities are classified as hospitals in Australia. The distinction between in-hospital and out-of-hospital services is not always obvious. It is important that patients talk with their GP/Specialist regarding the classification and likely out-of-pocket costs for their medical treatment, including any rebates paid through Medicare.

What services are not eligible for the EMSN?

In-hospital services are not eligible for the EMSN. Where people receive their treatment in-hospital as a private patient they are eligible for a Medicare rebate equal to 75 per cent of the MBS Fee. If they hold Private Health Insurance (PHI), they may also receive a rebate from their PHI fund.

The EMSN provides an increased Medicare rebate for eligible out-of-hospital services. It is not available for services for which a Medicare rebate is not paid and out-of-pocket costs for these services do not count towards the annual EMSN threshold.

What is EMSN benefit capping?

The EMSN benefit cap is the maximum amount of EMSN benefits payable for an MBS item regardless of the fee charged by the GP/Specialist. The full list of MBS items is available online on this website. The *Health Insurance (Extended Medicare Safety Net) Determination 2017* is the legislative instrument that provides the Minister for Health with the ability to apply maximum increases (caps) in Medicare benefits under the Extended Medicare Safety Net.

Why are some services capped?

Following an announcement in the 2009-2010 Budget, on 1 January 2010, some Medicare items were capped after they were identified as areas of concern in the Extended Medicare Safety Net Review Report 2009 (the Review report). The Review report showed that for some services, such as obstetrics and assisted reproductive technology (ART), the EMSN had been used by specialist doctors to raise their fees knowing the taxpayer would cover 80 percent of the fee rise. This has implications for people that have not qualified for the EMSN. The EMSN benefit is intended to be a patient benefit; it is not intended to be a mechanism for doctors to increase their fees.

Since 1 January 2010 a number of MBS services have been listed on the MBS with EMSN benefit caps in place. These services have been capped to maintain consistency with the existing capped items, or as a result of recommendations made by the Medical Services Advisory Committee (MSAC) regarding cost effectiveness.

The 2009 *Extended Medicare Safety Net Review Report* can be found on the Department of Health website.

Following an announcement in the 2012-13 Federal Budget on 1 November 2012, EMSN benefit caps were applied to all consultations (including allied health), 38 procedural items and one ultrasound item. The new caps are calculated based on a percentage of the MBS Fee.

For consultation items the EMSN benefit cap is set at 300 per cent of the MBS Fee, up to a maximum cap of $500. Therefore, if a consultation item has an MBS Fee of $100, the EMSN benefit cap is $300. If the consultation item has an MBS Fee of $200, the EMSN benefit cap is $500. Note: All consultations, including GP, specialist, consultant physician and allied health, will have an EMSN cap.

For the other ‘non-consultation’ items that were capped on 1 November 2012, the EMSN benefit cap is equal to 80 per cent of the MBS Fee. For these items there is no upper limit on the setting of the cap. Therefore if an item has an MBS Fee of $1,000, the EMSN benefit cap is $800.

How do the EMSN benefit caps work in practice?

Most people are not affected by capping. If you claim a capped item you still receive the standard Medicare rebate for the service and once you have reached the EMSN threshold

you are still eligible to receive EMSN benefits up to the amount of the EMSN benefit cap for all out-of-hospital services. EMSN benefit capping does not affect the way patients qualify for the EMSN, meaning that all out-of-pocket costs for all MBS services that have an EMSN benefit cap count toward the patient's EMSN threshold.

The EMSN benefit caps are recorded in the Department of Human Services (DHS) claiming systems and are applied by DHS at the time of processing the claim for payment.

How do I calculate my EMSN benefit?

For a capped item the method for determining the EMSN benefit is the same, that is, up to 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, the patient receives the EMSN benefit cap amount. If the calculated benefit is less than the EMSN benefit cap, the patient receives the calculated benefit (which is equal to 80 per cent of the out-of-pocket costs for the claim).

Out-of-pocket cost is the difference between the fee charged by the GP/Specialist and the standard Medicare rebate received by the patient from Medicare before EMSN benefits are paid.

The following scenario and examples illustrate how the EMSN caps work. They assume that the patient has already reached their EMSN threshold and is therefore eligible to receive EMSN benefits.

Scenario.

A consultation item has a:

- MBS Fee of $100;
- 85 per cent out-of-hospital rebate of $85; and
- 300 per cent EMSN benefit cap of $300.

Example 1.

If the doctor charges $120 for the service, the patient will receive:

- 85 per cent out-of-hospital rebate of $85; and
- 80 per cent of the remaining out-of-pocket amount or $300, whichever is the lesser amount. In this example [i.e. 0.8 * ($120 - $85) = $28].

This means that the patient will receive $113 ($85 + $28) from Medicare, and will be out-of-pocket $7 ($120 - $113).

Example 2.

If the doctor charges $500 for the service the patient will receive:

- 85 per cent out-of-hospital rebate of $85; and
- 80 per cent of the remaining out-of-pocket amount or $300, whichever is the lesser amount. In this example [i.e. 0.8 * ($500 - $85) = $332], therefore $300.

This means that the patient will receive $385 ($85 + $300) from Medicare, and will be out-of-pocket $115 ($500 - $385).

The full list of MBS items is available online on this website. Use the search function on the website to find any Medicare item and its associated MBS fees and rebates. If an item has an EMSN benefit cap, it will appear in the item description.

Further information

For more information visit the Medicare website or contact the Department of Human Services - Medicare:

Medicare
GPO Box 9822
in your capital city

Phone: 132 011 (local call rate) 24 hours 7 days a week.
Email: medicare@humanservices.gov.au

Further background on the EMSN is also available on the Department of Health website.

Items with an EMSN benefit cap

As at 1 January 2019, there are 686 MBS items with an EMSN benefit cap. To see if a medical service has an EMSN cap, search for the item number on this website.