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Health Alert

June 2013

Release of aged care modelling report – raises viability concerns for low care providers

On 22 May 2013, the Department of Health and Ageing (**DOHA**) released an interim financial modelling report sourced externally from KPMG and commissioned by the Aged Care Financing Authority (**ACFA**) regarding the potential financial impacts of proposed aged care accommodation payment changes as part of the Living Longer Living Better aged care reforms. Click here to view the report.

The external modelling was commissioned due to concern within the sector regarding uncertainty of the future viability of aged care providers, particularly regarding the move away from refundable accommodation deposits (**RADs**) (which make up $12 billion or 44% of industry aggregated assets) in favour of daily accommodation payments (**DAPs**). This change could affect the viability of future projects without an injection into the industry from other sources, as the pool of funds in the form of RADs are used to a significant extent to sustain current levels of borrowing within the sector.

The KPMG report analyses the possible choice of an individual to pay by DAP or RAD, the impact of that choice on providers (including the impact of the removal of legislated retention amounts), the impact of the removal of the current cap on high-care accommodation prices and the impact of the proposed changes extending RAD payments to high-care residents. The analysis assumes that the resident's choice is made solely on the basis of what is in their best interests financially. There are other significant limitations to the modelling, including the inability to predict outcomes for future years and the assumptions made about the financial situations of residents.

The model estimates that in the first year of the reforms there will be an increase of $3.4 billion in RADs from new residents accessing High Care Services (other than Extra Services). Further because of the removal of capping arrangements there is going to be an estimated $93.5 million increase in provider income.

Conversely, the model estimates that in the first year of reforms, Low Care and Extra Services will see a decrease in the number of new RADs from new residents to the tune of $402.8 million. And because of the removal of retention amounts, but not accounting for a potential offsetting increase in revenue that may arise if residents choose to make combination payments under the new arrangements, including draw downs from lump sum payments, there will also be an estimated decrease in income of $68.4 million in the first year of reforms.

The conclusion that the majority of new entrants in Low Care and Extra Services would choose to pay a DAP is largely a result of the assumption that residents will always make decisions to maximise wealth. This outcome is problematic because in the majority of cases the income earned from renting out the home would not be sufficient to pay the estimated DAP.

A summary of the impact of these changes in the first year of the LLLB reforms at the aggregate industry level is set out below.

	Balance Sheet impact $m	Profit and Loss impact $m
High Care	3,400	93.5
Low and Extra Service	-402.8	-68.4

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There may be a slight offset of the value of new RADs for new High Care (other than Extra Services) residents from the small reduction in new RADs for Low Care and Extra Service residents entering care who elect to pay by a DAP.

According to the DOHA media release (click here), 'ACFA supports the overall findings of the analysis that the reforms can be expected to have a significant positive impact on the overall level of refundable accommodation deposits (bonds) and revenue for the industry.'

It is important to note that both ACFA and KPMG acknowledge that the findings of the report are limited in terms of the way in which the proposed reforms may impact residential aged care providers differently based on the different circumstances of providers, with profitability, capital structures, business models and ability to adapt to the proposed changes all impacting upon the potential effects of the changes. It is also noted that compared with High Care providers, Low Care and Mixed Care providers may suffer to a greater negative extent financially from the proposed changes, with careful continued monitoring to be undertaken in this regard by ACFA.

Low Care and Mixed Care providers in particular should make themselves aware of this report and its findings. Continued monitoring is required, as submissions to Government across the industry may begin to occur should it be identified that transitional support will be required to ensure Low and Mixed Care providers continue to remain viable under the proposed new arrangements.

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Have your say: collecting financial data on aged care services – submissions due 8 July 2013

The role of the Aged Care Financing Authority (**ACFA**) is to provide independent advice to the Minister for Health and Ageing on pricing and financial issues arising from the aged care sector.

ACFA is about to release its first Annual Report to the Minister which is intended to form the baseline from which changes in the sector can be measured. Along with its annual reporting obligations, ACFA is sourcing a range of analysis and reporting projects, including the KPMG report also discussed in this edition of the Health Alert.

ACFA has found that there is a dearth of consistent, reliable and comparable data about the provision of aged care services in Australia. This will hamper ACFA's ability to benchmark and establish a meaningful pricing framework.

Accordingly, ACFA has released this discussion paper seeking feedback on (as a minimum):

- any concerns with the current reporting arrangements for residential care, home care, or the Commonwealth HACC Program
- the costs and benefits that could arise from:
  - requiring residential care providers to submit financial data against a segment note format with compulsory items
  - obtaining better information at the residential aged care service level e.g. segment note income statement level information at the residential care service level
- potential areas for rationalisation of reporting such as reducing duplicate reporting (e.g. bond data is collected in the resident entry record and the Survey of Aged Care Homes) and whether any existing reports could be combined
- reporting that would assist the Authority monitor the impact of *Living Longer Living Better* reforms (e.g. monthly collection: of outgoing bonds, periodic payments and accommodation charges; and incoming refundable deposits and daily accommodation payments)
- options for improving home care reporting
- options for improving Commonwealth HACC Program reporting
- the best way to collect information (e.g. annual reports, surveys) and how technology could be used to improve the information collected (e.g. online collection and surveys).

Click here to view the discussion paper

Submissions are due 8 July 2013

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ACCC publishes annual review of health insurers and considers recognition of allied health providers

The Australian Competition and Consumer Commission (**ACCC**) released its annual 'Report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance' on 22 March 2013. This is the fourteenth report prepared by the ACCC complying with an order agreed by the Australian Senate in March 1999, and covers the period 1 July 2011 to 30 June 2012.

Broadly, the report reviews whether any anti-competitive practices by health insurers or providers are occurring which reduce the extent of health cover for consumers or increase their out-of-pocket medical and other expenses. Typically the annual report addresses various issues relating to the private health insurance industry including, for example, contracting, preferred provider schemes and second-tier default benefits. The report identified that, while those areas remain relevant to the industry, no new developments had arisen. As a consequence, the report focused on a single issue not previously examined, but which has generated complaints and submissions to the ACCC. This new issue for review is the practice of private health insurers in not recognising certain types of allied healthcare providers who offer the same or similar services as other types of 'recognised' providers.

The ACCC identified that the reason this issue arises is due to the significant crossover of activities of various categories of allied healthcare providers, with the example given that foot orthotics may be prescribed by both an orthotist and a podiatrist. However, the majority of insurance providers only recognise podiatrists for the provision of this service, which results in only the podiatrist receiving the offer of a rebate. The ACCC then undertook its investigation to examine whether the existence of this issue placed non-recognised providers at a competitive disadvantage and negatively impacted consumers, in particular those consumers that preferred the services of non-recognised providers.

The ACCC's findings can be summarised as follows:

- Private health insurers recognise at least one category of provider for each service covered by their products, however in remote areas some members may experience difficulty accessing services of recognised providers due to fewer providers in rural areas.
- Submissions regarding non-recognised providers found that some of their services were recognised by insurers, although significant variation was evident. The example given to illustrate the variation was that some insurers recognised dieticians and not nutritionists, others recognised nutritionists and not dieticians, and some insurers recognised both.
- There are no legal or regulatory impediments prohibiting insurers from choosing to recognise or not recognise allied healthcare providers. The insurer makes their decision on a commercial basis.
- Factors insurers take into account in deciding whether to recognise categories of allied health providers include, first and foremost, clinical efficacy of the service and related clinical risks (a relatively costly process usually contracted to agencies with specialist knowledge), member demand, administration costs, total claim costs and insurance premiums, and whether including an additional service will attract new members.
- Allied healthcare providers did not appear to be aware of the above factors regarding insurers' decisions on whether to recognise healthcare providers.
- The recognition practices of insurers can result in increased out-of-pocket expenses for some consumers (but with potentially lower insurance premiums) and lower health coverage than they prefer (but not relative to what they have paid for).
- The ability for consumers to use coverage they have paid for depends on location rather than insurer decisions regarding new provider recognition.
- The decision to recognise providers is based on the commercial judgment of insurers, with the ACCC not purporting to require any or all allied healthcare providers be recognised.

The overall findings of the report indicate that if an insurer does not recognise a category of allied healthcare providers, the employment prospects and income of those providers can be affected. However, where insurers are well informed of the preferences of their members, non-recognition should not, on balance, harm consumers. Consumers may have greater out of pocket expenses for their preferred, non-recognised services, however they do not contribute to the cost of that provider through their insurance premium. Further, insurers are likely to recognise particular providers that are preferred by a significant number of their members.

Where insurers are not well informed of the preferences of their members, potentially due to a lack of information being given to consumers as to the categories of recognised allied healthcare providers and the services

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covered, the decision to recognise one category of provider over another may distort competition between recognised and non-recognised providers.

The ACCC suggests that with more detailed and transparent disclosure by insurers, consumers would be better able to make informed insurance decisions, which in turn would give insurers clearer signals of members' preferences as to the allied healthcare provider services most desired. An increase in transparency about the categories of allied health providers that insurers recognise and a greater knowledge of consumer preferences could '*fast-track insurer recognition of some currently unrecognised allied healthcare providers*'.

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Statutory definition of charity

The Commonwealth has released a draft Bill for a statutory definition of 'charity' that would apply for the purposes of all federal laws. For our analysis of the draft Bill, please click here to view our latest Charity Alert.

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DisabilityCare – a change of name, not a change of focus

Minister for Disability Reform, the Hon Jenny Macklin MP, announced on 18 March 2013 that the National Disability Insurance Scheme now has a name – DisabilityCare Australia.

In a low key joint media release (click here), the Minister is quoted as stating that 'DisabilityCare Australia reflects the principles of the NDIS – that all Australians with significant or profound disability receive the care and support they need, regardless of how they acquired that disability'.

Ms Macklin goes on to say that 'the name has been chosen based on consultations with people with disability, their families and carers, peak organisations and the general public.' It would appear as though the name was chosen to sit alongside Medicare and be easily recognisable as a permanent insurance scheme. However, there has been criticism among certain stakeholders regarding the change of name, particularly relating to the use of the term 'care' and the way in which this reflects notions of reliance as opposed to notions of independence and choice that the new scheme affords.

The Federal Government does not appear intent on changing the name, with the furore surrounding the new name likely to subside over time. The new name does not overshadow the importance of the historic legislative reform, touted as the most significant health reform legislation since the introduction of what is now known as Medicare in 1975. The first legislative instrument to use the name, the *DisabilityCare Australia Fund Act 2013* (Cth), will be discussed in the Legislation Update of this Alert.

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Legislation update

Commonwealth Legislation

***DisabilityCare Australia Fund Act 2013* (Cth)**

The Act received assent on 28 May 2013, and establishes the DisabilityCare Australia Fund, comprising of the DisabilityCare Australia Fund Special Account and the investments of the DisabilityCare Austalia Fund.

The Act also establishes transitional measures to operate during the implementation of the National Disability Insurance Scheme Act 2013 known as the DisabilityCare Australia Transitional Special Account.

The funding of DisabilityCare Australia and the associated insurance scheme will come from a 0.5% levy on a person's taxable income, which will see the Medicare levy increase from 1.5% to 2% of taxable income from 1 July 2014.

The Act outlines the way in which funds raised from the Medicare levy increase will be used, along with other related functions:

- **Credits** – the Treasurer will credit the DisabilityCare Australia Fund Special Account on the advice of the Australian Taxation Office regarding the revenue received from the increased Medicare Levy.
- **Debits** – the Finance Minister is permitted to debit the

Special Account to reimburse States and Territories for expenditure relating to DisabilityCare Australia.

- **Investment** – investment of the funds in the Special Account will occur under the same mandate of the Future Fund Board, with the responsibility of investment vesting in this Board.
- **Earnings** – any earnings will be retained for the benefit of the Commonwealth. The earnings will also be used to cover the costs of investment associated with the Future Fund Board, the Medicare levy will not be used to cover these costs.
- **Reporting** – the Finance Minister is responsible to report on the balances of the DisabilityCare Australia Fund Special Account.
- **Transitional Special Account** – this account is to be administered by the Department of Families, Housing, Community Services and Indigenous Affairs throughout the initial implementation stages of the National Disability Insurance scheme as set out in the *National Disability Insurance Scheme Act 2013*.

Medicare Levy Amendment (DisabilityCare Australia) Act 2013 (Cth)

The *Medicare Levy Amendment (DisabilityCare Australia) Act 2013* was assented to on 28 May 2013. The Act legislates for the increase in the Medicare levy from 1.5% to 2% which will be used to fund DisabilityCare Australia.

National Disability Insurance Scheme Act 2013 (Cth)

The National Disability Insurance Scheme Bill 2013 was first introduced to Parliament on 29 November 2012. An overview of the scheme was included in the December 2012 Health Alert (click here). The Bill underwent significant debate throughout February and March Parliamentary sessions in 2013, leading to the introduction of a range of amendments to the initial Bill. The Act received assent on 28 March 2013 and commences on 1 July 2013.

Notable amendments to the initial Bill include, but are not limited to, the:

- alignment of the Bill with Australia's international obligations regarding the Convention on the Rights of Persons with Disabilities to reinforce the fact that the NDIS is focused on the rights of people with disabilities, their families and carers;
- clarification that people requiring early intervention support for degenerative health issues can access support through the NDIS where this will offer better support than existing systems;
- clarification on age thresholds allowing people to stay in the NDIS after they turn 65, but not if they acquire a disability after 65 (in which case they will be supported through the aged-care system);
- compensation provision changes which now allow the NDIS Launch Transition Agency to act on behalf of a person with a disability that does not wish to conduct legal proceedings;
- support for requirements for representation of people with a disability on the NDIS Advisory Council; and
- introduction of actuarial advice to be received and considered by the NDIS Board to strengthen the financial sustainability of the NDIS.

Click here to view the whole Act.

National Disability Insurance Scheme Legislation Amendment Act 2013 (Cth)

The National Disability Insurance Scheme Legislation Amendment Bill 2013 (Cth) was assented to on 28 May 2013 and commences on 1 July 2013. The explanatory memorandum outlines the objective of the Act is to 'clarify the policy intention in relevant provisions, and to address minor anomalies and technical errors', and the Act:

- regarding early intervention supports, 'where there is no intention to make rules and where key eligibility criteria are set out clearly in the legislation', removes the current rule-making power;
- strengthens the governance and financial framework of DisabilityCare Australia;
- 'clarifies the intended operation of provisions relating to compensation claims', including ensuring protections for claimants in line with the *National Disability Insurance Scheme Act 2013* (Cth); and
- makes consequential amendments to other Commonwealth Acts to complement the NDIS Scheme, including the *Administrative Appeals Tribunal Act 1975* and the *Social Security Act 1991*.

Click here for a detailed review of all of the changes introduced by this Act.

Charities Bill 2013 (Cth)

The Charities Bill 2013 (Cth) was introduced to the House of Representatives on 29 May 2013, and represents a response to the 2001 *Report of the Inquiry into the Definition of Charity and Related Organisations*. The Bill proposes to introduce definitions of charity and charitable purpose, the first comprehensive Commonwealth definition in statute. The explanatory memorandum outlines that ' the

statutory definition generally preserves the common law principles by introducing a statutory framework based on those principles but incorporating minor modifications to modernise and provide greater clarity and certainty about the meaning of charity and charitable purpose.' Changes to the definition are to apply from 1 January 2014.

For comprehensive detail of the new definition, click here to view the Bill.

Charities (Consequential Amendments and Transitional Provisions) Bill 2013 (Cth)

This Bill was introduced into the House of Representatives and received its second reading speech on 29 May 2013. The Bill makes minor changes to reflect statutory definitions of 'charity' and 'charitable purpose' outlined in the Charities Bill 2013 (Cth). Click here to view the Bill.

National Health Reform Amendment (Definitions) Bill 2013 (Cth)

The Bill seeks to amend the principal Act, the *National Health Reform Act 2011* (Cth). As evident in its name, the Bill proposes to change some definitions in the principal Act, including 'local hospital network', 'public hospital', 'private hospital' and 'primary health care organisation'.

Click here to view specifics of these new definitional changes.

Privacy Amendment (Privacy Alerts) Bill 2013 (Cth)

This Bill was introduced to the House of Representatives and received its second reading speech on 29 May 2013. The Bill proposes to amend the *Privacy Act 1988* (Cth). The changes proposed by the Bill are additional to the *Privacy Amendment (Enhancing Privacy Protection) Act 2012* reforms which have been discussed in detail in both the June 2012 (click here) and December 2012 (click here) Health Alerts. The changes being proposed are to come into effect in March 2014 alongside the previously discussed reforms.

The explanatory memorandum establishes that the purpose of the Bill is to introduce mandatory data breach notification provisions for agencies and organisations regulated by the *Privacy Act 1988* (Cth). This is change adopts an Australian Law Reform Commission recommendation from the 2008 Report *For Your Information: Australian Privacy Law and Practice*. Specifically, the Bill:

- defines 'serious data breach';
- requires agencies and organisations to provide notice to the Australian Information Commissioner and individuals as soon as reasonably practicable in the event of a serious data breach;
- provides what should be included in the notice, including a description of the breach and the information concerned;
- provides for notice to be published online and in print media where it is impossible or impracticable to notify each affected individual;
- reiterates exemptions in the *Privacy Act* (including for intelligence agencies and small businesses);
- gives the Information Commissioner the power to force an organisation or agency to notify of a breach where no notification has been given; and
- provides that failure to comply with the Bill will be deemed an interference with the privacy of an individual for the purposes of the Privacy Act, allowing for the existing powers of the Information Commissioner to be activated (including new powers coming into force in March 2014).

Private Health Insurance Legislation Amendment (Base Premium) Bill 2013 (Cth)

This Bill was introduced to the House of Representatives on 15 May 2013 and is currently undergoing debate following the Bill's second reading. The Bill's primary goal is to reduce Government expenditure on the private health rebate offered as an incentive to encourage Australians to obtain private health insurance.

The explanatory memorandum outlines that the Bill proposes to make the rebate more sustainable by 'linking the amount of the Rebate to 2013 premium prices. From 1 April 2014, increases to the Rebate in future years will be indexed by the lesser of the CPI or the percentage change for the premium charged by a private health insurer.'

NSW Legislation

Health Administration Act 1982 (NSW)

The amendments to this Act:

- allow for the Health Administration Corporation to dispose of land in the same manner as that permitted by local health districts under section 34 of the *Health Services Act 1997*;
- allow for a person to be appointed to a fourth consecutive term on the Medical Services Committee

only when they were appointed Chairperson during their third consecutive term.

Health Care Complaints Act 1993 (NSW)

The amendments to this Act:

- outline the principles governing the Health Care Complaints Commissions exercise of its functions, along with other government agencies related to the health care complaints process under the Act (see the link below for the full list of inserted principles);
- include minor changes to wording with the effect of allowing complaints to extend to action that is ***likely*** to affect the clinical management or care of an individual client, which broadens the scope of complaints which previously only covered action that ***affected*** clinical management or care;
- provides the Health Care Complaints Commissioner with the authority to make complaints in certain circumstances (see link below for detailed circumstances);
- requires the Commission to give an employer of the person the complaint concerns notice of the complaint, the nature of the complaint and the identity of the complainant if the commission considers on reasonable grounds that the giving of notice is required to protect the health and safety of the public or member of the public;
- provides that the Commission is not required to give notice where it appears on reasonable grounds that the giving of notice could place the complainant or another person at risk of intimidation, harassment or unreasonably prejudice the employment or engagement of the health practitioner;
- provides that the Commission is required to give notice to all the parties to the complaint regarding the action taken or decision made, not just to the complainant;
- provides that the Commission may additionally notify other persons of the action taken and reasons for taking that action regarding complaints against a health organisation;
- includes other minor amendments.

Health Legislation Amendment Act 2013 (NSW)

The Act was assented to on 14 May 2013. The initial Health Legislation Amendment Bill 2013 (NSW) was amended on its passage through Parliament. The Act as it stands makes a variety of amendments to a variety of Acts including the:

- *Health Administration Act 1982* (NSW);
- *Health Care Complaints Act 1993* (NSW);
- *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW);
- *Health Services Act 1997* (NSW);
- *Mental Health Act 2007* (NSW); *and*
- *Mental Health (Forensic Provisions) Act 1990* (NSW)

Health Services Act 1997 (NSW)

- The amendments insert a new section 120A into the Health Services Act 1997. The title of this new section is 'Suspension of members of staff from duty pending decision in relation to misconduct or serious criminal charge' and affords the Director-General of the Ministry of Health the power to suspend members of the New South Wales Health service, without pay, in certain circumstances, such as misconduct or serious criminal charges. For more detail, see the link below.

Health Practitioner Regulation (Adoption of National Law) Act 2009 (NSW)

The amendments to this Act:

- provides that the Health Care Complaints Commission is not required to investigate the complaint or cause it to be investigated if the matter that is the subject of the complaint is being, or has been, investigated as, or as part of, another complaint to the Commission;
- includes other minor amendments, such as changing references from Governor to Minister.

Mental Health Act 2007 (NSW)

The amendments to this Act:

- make clear that a correctional patient re-classified under the *Mental Health (Forensic Provisions) Act 1990* as an involuntary patient is an involuntary patient under the principal *Mental Health Act 2007*;
- provides that the Mental Health Review Tribunal must be notified as soon as reasonably practicable by an authorised medical officer of a mental health facility that a person detained is a forensic patient. Notification must also be made upon discharge of a forensic patient.

Mental Health (Forensic Provisions) Act 1990 (NSW)

The amendments to this Act:

- clarify when a person is no longer classified as a forensic patient under the *Mental Health (Forensic Provisions) Act 1990*;

- provide that a community treatment order may be made in accordance with an order of the Mental Health Review regarding the unconditional release of a forensic patient;
- clarify that a s68 apprehension order authorises the detention of the person concerned at the place specified in the order;
- clarify that the *Mental Health Act 2007* applies to persons granted conditional release or leave of absence under part 5 of the *Mental Health (Forensic Provisions) Act 1990*;
- include amendments to section 77A to ensure that the Supreme Court and the Mental Health Review Tribunal can suspend the operation of an order relating to forensic patients if an appeal is made on a question of law ***or*** fact (previously suspension was only applicable to questions of law).

Click here to view the Bill.

Public Health Amendment (Vaccination of Children Attending Child Care Facilities) Bill 2013 (NSW)

The Public Health Amendment (Vaccination of Children Attending Child Care Facilities) Bill 2013 has passed through the Legislative Assembly and is currently awaiting its second reading in the Legislative Council.

Generally, the Bill is designed to lift vaccination rates, which have fallen below 90% in some areas of New South Wales. The Bill seeks to lift vaccination rates where parents have forgotten or have not got around to ensuring their child's vaccination is up to date.

The Bill proposes to prevent the enrolment of children at child care facilities where immunisation certificates cannot be provided to prove that the child is adequately vaccinated. Exceptions may apply on the grounds of conscientious objections or medical reasons. The bill will impose a requirement on child care facilities to keep immunisation certificates and records in an immunisation register. The Bill introduces fines for child care providers for non-compliance with the new rules.

Click here to view the Bill.

Rights of the Terminally Ill Bill 2013 (NSW) – voted down in Upper House

The Rights of the Terminally Ill Bill 2013 (NSW) was defeated in the NSW Upper House by a margin of 23 to 13. The Bill aimed to provide a regulatory framework giving the terminally ill the right to request and receive assistance to end their lives voluntarily. It is expected that a similar Bill will be resubmitted to the Lower House in the near future.

Click here to view the Bill.

For further information, please click here to contact our national Health, Aged Care and Retirement Villages team

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