Australian Government
Department of Health, Disability and Ageing

Modernising gap-only billing – replacing Medicare cheques with electronic benefit payments

[Draft Impact Analysis for consultation – December 2025]

Prepared by Department of Health, Disability and Ageing

This Impact Analysis (IA) has been developed in accordance with *The Australian Government Guide to Policy Impact Analysis*.

This IA will be used to inform Government's consideration of options for modernising gap-only billing as a component of the Winding Down Cheques measure.

Contents

Executive Summary

Medicare is a universal health insurance system supporting fair and affordable health cover for all Australians. Medicare subsidises the cost of medical services, prescription medications, and provides free services for public patients in public hospitals. This supports Australians to access the health care they need to enjoy good health outcomes regardless of their income or socioeconomic status.

Through its oversight responsibilities of setting Medicare Benefit Schedule (MBS) fees to support payment for services, the Australian Government plays a crucial role in enabling equitable access to cost effective health care.

Under current Medicare billing arrangements, health care providers can choose to charge patients in one of three ways:

i. Bulk billing - the Medicare benefit is accepted as full payment for the service.
ii. Gap-only billing – the patient pays the gap amount only and the provider receives the Medicare benefit in the form of a cheque sent via the patient (called Pay Doctor Via Claimant or PDVC).
iii. Patient billing - the patient pays the full fee at the time of service and receives a Medicare rebate.

The Treasurer, the Hon Dr Jim Chalmers MP, announced 'Australia's Cheques Transition Plan' on 18 November 2024, which will phase out cheques by 1 July 2028. The government announced in the Mid-Year Economic and Fiscal Outlook 2025-26 a new Medicare electronic gap-only billing system to replace current Pay Doctor via Claimant arrangements. Refer to www.Budget.gov.au and search for 'Appendix A: Policy decisions taken since the 2025 PEFO' on page 290.

After that time the Government will cease issuing Medicare benefits cheques and Child Dental Benefit Schedule (CDBS) cheques. This means that current gap-only billing arrangements will need to be removed or reformed.

This impact assessment assesses the following options:

Option 1 - Removal of gap-only billing (via PDVC arrangements) with no replacement

Option 2 - Modernise gap-only billing arrangements to assist with affordability of high cost medical services. Gap-only billing would be removed from the CDBS.

Under Option 1, the removal of gap-only billing with no replacement would leave patient billing and bulk billing as the only ways of charging and processing claims for Medicare benefits.

Under Option 2, patients would pay the gap amount only at the time of service. The Medicare benefit would be paid by Medicare to the provider via direct electronic funds transfer (EFT). To preserve the attractiveness of bulk billing the payment of the Medicare benefit would be delayed by 90 days. Gap-only billing would be confined to high cost medical services - approximately 30% of Medicare items - to discourage price inflation and encourage bulk billing for lower cost services.

Gap-only billing would be removed from the Child Dental Benefit Schedule which has high bulk billing rates.

Introduction

Medicare

Medicare is Australia's national health insurance scheme. It was established to subsidise the cost of private medical services and approved medications, and to provide free care for public patients in public hospitals. Introduced on 1 February 1984, following the passage of the *Health Legislation Amendment Act 1983*, the then Minister for Health, Dr Neal Blewett, described Medicare as a simple, fair, affordable insurance system that provides basic health cover to all Australians.[1]

The provision of high-quality affordable care to all Australians remains a guiding principle of Medicare.

All providers who provide services eligible for Medicare benefits can use current gap-only billing via PDVC arrangements.

In 2024-25, $186 million in Medicare benefits was paid to providers using PDVC billing, representing less than 1% of total Medicare expenditure ($32 billion) and 0.05% of CDBS expenditure. Providers used PDVC billing for 1.3 million services representing less than 1% of all Medicare services. Of those services, 37% were billed to patients who were concession card holders including those with Pensioner Concession Cards, Health Care Cards and Commonwealth Seniors Health Cards. Around 870,000 cheques are issued each year.

In 2024-25, 20% of all Australian health providers offered PDVC billing to 2.5% of patients on at least one occasion during that year. It is assumed that many of these patients could not afford to pay the full fee at the time of service. Currently, providers use PDVC billing for a mix of high cost and lower cost Medicare services.

Peak medical organisations have indicated that providers would use modernised gap-only billing arrangements.

Retaining gap-only billing arrangements would continue to allow patients to pay a partial fee - the gap component only - at the time of service.

[1] Biggs, A.(2004). *Medicare – Background Brief.* Australian Parliamentary Library. 8823863.pdf;fileType=application/pdf

1. What is the policy problem you are trying to solve and what data is available?

1.1. Policy Problems

1.1.1. Government will cease cheques, making PDVC arrangements obsolete

The Government aims to cease issuing cheques by 1 July 2028. PDVC arrangements rely on the government paying Medicare benefits via cheque. PDVC arrangements cannot be continued after the government ceases issuing cheques.

1.1.2. Should obsolete PDVC arrangements be replaced with modernised gap-only billing arrangements?

PDVC arrangements are the only arrangements which enable the patient to pay the gap component only of the total fee at the time of service.

If PDVC arrangements - where a cheque is sent to the provider via the patient - were replaced with modernised gap-only billing arrangements (EFT to provider), this would continue to allow patients to pay the gap amount only, thereby assisting with service affordability. Modernised gap-only billing arrangements would allow providers to bill the gap amount only for high cost services, where the Medicare benefit component alone can be several thousands of dollars.

1.1.3. Gap-only billing discourages bulk billing and encourages service price inflation

Despite the benefits of gap-only billing i.e., assisting with affordability up front (at the time of service), this form of billing has the potential to discourage bulk billing and encourage service price inflation. By allowing patients to pay the gap component only, fees appear less expensive to the patient at the time of service because the Medicare benefit component is 'hidden'. This is likely to encourage some providers to charge a larger gap to patients who might otherwise have been charged a smaller gap. Similarly, some providers are more likely to ask patients who might otherwise have been bulk billed (no gap) to pay a gap amount. Medicare data indicates that overall fees are sometimes higher where gap and benefit components are split (i.e., in gap-only billing where the gap component only is visible), than where the components are combined.

Medicare data also shows that around 40% of patients billed under PDVC arrangements are concessional patients. Some of the services provided to these patients would attract a bulk billing incentive paid to the provider if the provider chose to bulk bill the patient instead of charging a gap.

1.1.4. For lower cost services gap-only billing arrangements are less useful

As lower cost services are more affordable than higher cost services, there is less patient demand for gap-only billing for lower cost services.

Additionally, from 1 November 2025 bulk billing incentives were put in place for GP non-referred Medicare attendances and fully bulk billed practices, regardless of a patient's age or concession card status.

Including lower-cost services in gap-only billing arrangements would expose them to the risk of price inflation associated with split component billing (described in 1.1.3). The inflationary risk can be mitigated by excluding lower cost services from gap-only billing arrangements.

1.1.5. Gap-only billing arrangements are not needed for Child Dental Benefit Schedule services

Gap-only billing arrangements are not needed to maintain affordability for CDBS services. Gap fees in CDBS services are rare and 98% of CDBS services are bulk billed.

1.2. Data availability and limitations

Medicare data on current PDVC arrangements is not sufficiently indicative of the extent to which modernised gap-only billing would be requested by patients or used by providers. Current PDVC arrangements are used in less than 1% of all Medicare services. Modernised gap-only billing arrangements would be more efficient and provide clear benefits to the provider (direct payment via EFT) and to the patient who, in addition to experiencing continued affordability, would no longer need to deliver the cheque to the provider.

The effect of modernised gap-only billing arrangements would be monitored in a post-implementation review. While Medicare data does not show why providers bill using PDVC arrangements, or the extent to which patients can afford the full fee, qualitative data from peak medical organisations and providers may be examined during a post-implementation review.

Unless stated otherwise, data is based on the date of service of the Medicare claim for services provided in the financial year (including claims for that year that are submitted in a later financial year).

1.3. Exclusions

1.3.1. Broader Medicare issues

Measures announced by the Government over recent Budgets aim to improve bulk billing, the health workforce, enable cheaper medicines, expand Medicare and medicines for women and boost funding for public hospitals. During 2025 for example the Government has implemented options for strengthening Medicare through the Strengthening Medicare measures (refer to www.health.gov.au and search for Strengthening Medicare).

Medicare issues that are not within the scope of this examination include other affordability drivers such as:

- the extent to which patients can afford to pay the full fee or the gap only at the time of service;
- the reasons why providers choose to bulk bill, or charge patients a gap only, or the full fee.

1.3.2. Other exclusions

Retaining current PDVC arrangements has been excluded as an option as the Government will cease issuing cheques on 1 July 2028.

While this IA addresses the options available to the Government to manage Medicare payment arrangements, providers and patients may have access to other financial assistance services that are outside the scope of this IA.

2. What are the objectives, why is government intervention needed to achieve them, and how will success be measured?

2.1. Objectives

Gap-only billing arrangements, such as the current PDVC arrangements, are designed to support affordability by assisting patients to pay for Medicare service costs where the provider chooses to charge the patient a gap amount in addition to the Medicare benefit, rather than bulk billing. Gap-only billing arrangements are intentionally designed to be less attractive to providers than bulk billing.

The objectives of implementing modernised gap-only arrangements are:

Objective 1 – To improve the affordability of high cost Medicare services

The first objective is to make available a billing method to improve the affordability of high cost Medicare services. Providers could use gap-only billing when the provider chooses not to bulk bill the patient. Instead, the provider allows the patient to pay a gap amount only at the time of service, rather than having to pay both the Medicare benefit and gap amount up front.

Sub-objective 1A – To preserve bulk billing rates

This objective preserves bulk billing rates by making gap-only billing somewhat less attractive relative to bulk billing. This would be achieved with a 90 day payment delay before the Medicare benefit is paid to the provider.

Sub-objective 1B – To discourage service price inflation in lower cost Medicare services

This objective discourages fee inflation in lower cost services by excluding lower cost services from the arrangements.

Objective 2 – To improve gap-only billing efficiency

The second objective is to improve the efficiency of current gap-only arrangements via PDVC. Efficiencies would be achieved by paying the Medicare benefit to providers directly and electronically.

Any Medicare Safety Net entitlements would be paid directly to the patient electronically, in line with usual Medicare payment arrangements.

2.2. Limitations of gap-only billing

No paper-based claims (electronic only)
Gap-only billing arrangements would not process paper-based Medicare claims. Claims under gap-only arrangements would be processed electronically.

Providers with internet access would retain access to register for electronic claiming. Providers would be able to submit gap-only claims online. Providers who are not registered to submit claims electronically would not be able to choose gap-only billing arrangements. These providers could continue to submit paper-based claims using patient billing or bulk billing arrangements.

2.3. Role of Government

Medicare is Australia's universal health insurance scheme that provides free treatment for public patients in public hospitals and provides 'benefits' for private services listed on the Medicare Benefits Schedule (MBS). The Government is responsible for administering this funding, including making decisions about what medical services will be listed on the MBS, the fees for services, and any associated affordability measures. Government decisions on which services and fees will be listed on the MBS are informed by the Medical Services Advisory Committee and the MBS Review Advisory Committee. The Government pays Medicare benefits to patients via Services Australia's claims and payments systems.

2.4. Rationale for Government intervention

The Government is leading a transition away from cheques. If the Government considers that gap-only billing arrangements are needed to assist with service affordability, then Medicare benefits would need to be paid to providers. This would require the development of modernised gap-only billing arrangements through legislative amendments to the *Health Insurance Act 1973* and a new payment system. Removing these arrangements from the Child Dental Benefits Schedule would require legislative amendments to the *Dental Benefits Act 2008*. Any arrangements chosen by Government would commence by the date that cheques are ceased (1 July 2028).

2.5. Limitations of Government intervention

The Government does not regulate gap fees or billing choices of providers.

Providers are free to set their own fees for the services they provide. There is no cap on the amount providers can charge for their services. Providers are also free to determine the billing method by which they charge patients.

Government can however apply competitive and restrictive pressures to influence fees through the design of Medicare. For example, Government can change the fee and benefit amounts for items listed on the Medicare Benefits Schedule. Government can also provide safety net payments to patients who meet certain out-of-pocket thresholds and other criteria. Safety net payments can be capped to discourage excessive inflation of overall service price.

2.6. Measuring success - efficiency and effectiveness of gap-only billing

Success would in part be measured by having more efficient 'gap-only billing' arrangements featuring direct, electronic payments, instead of current PDVC arrangements where payments are indirect (via the patient) and posted in the form of a paper cheque.

The effectiveness of gap-only billing is difficult to measure. Ideally, effectiveness would be measured by the extent to which gap-only billing makes services more affordable. An assessment of the impact of gap-only billing on quantitative indicators, such as bulk billing rates and out-of-pocket costs, would not necessarily constitute an assessment of affordability.

Understanding the impact on affordability of gap-only billing would require the identification of the most likely alternative billing option - patient billing or bulk billing - at the time of service. Without knowing which alternative billing option would have been taken had gap-only billing not been used, it is difficult to know whether the service might have been less affordable (had the alternative been patient billing) or more affordable (had the alternative been bulk billing). In addition, patient characteristics - such as income or household expenditure - are not available in Medicare data.

Peak medical organisations have advised that some providers would choose to offer gap-only billing to some patients who are currently charged the full fee at the time of service, thereby making these services more affordable. Affordability would be negatively impacted, however, if gap-only billing is used where the alternative option would have been bulk billing.

Bulk billing would be encouraged through applying a 90 day delay to the payment of the Medicare benefit to the provider under gap-only billing arrangements.

2.7. Potential barriers to success

The key barrier to success would be the extent to which providers view modernised gap-only billing as an opportunity to reduce up front costs to patients or as an opportunity to boost business income by increasing gap charges.

2.8. Alternatives to gap-only billing

If the Government chooses not to provide gap-only billing arrangements, providers would no longer be able to charge patients the gap amount only. Providers could instead choose either patient billing (full charge) or bulk billing (no gap).

2.9. Timing of considering gap-only billing arrangements

If the Government decides to modernise gap-only billing, implementation would be required before the government ceases issuing cheques in July 2028.

3. What policy options are you considering?

3.1. Summary of considered options

The following policy options have been considered to meet the stated objectives.

Option 1: Remove PDVC arrangements with no gap-only billing replacement.

Option 2: Replace PDVC arrangements with modernised gap-only billing arrangements for high cost services.

Retaining current PDVC arrangements has been excluded as an option because the Government will cease issuing cheques on 1 July 2028.

3.2. Option 1 - Remove PDVC arrangements with no gap-only billing replacement

During 2024-25, around 39,000 providers chose to bill 588,000 patients using PDVC arrangements. In 2024-25 providers charged a fee above the Medicare rebate for around 117 million services ($11 billion in Medicare benefits) representing 25% of all 475 million Medicare services.

Removing PDVC arrangements is likely to increase the risk that patients would not be able to access services. This may result in some patients delaying access to care or refusing care, potentially impacting their health. Other patients may seek public sector care, if a public sector alternative is available. Where public sector alternatives are not available the impact on service access, affordability and patient outcomes may be higher.

Without a gap-only billing arrangement, providers would no longer have the option to bill the patient the gap component only of the total fee. Providers would have to either bulk bill or charge the full fee (patient billing).

3.3. Option 2 – Modernised gap-only billing arrangements for high cost services

If the Government decides to replace PDVC billing arrangements with modernised arrangements allowing patients to pay the gap amount only, this impact analysis proposes a new model of gap-only billing to meet the objectives of affordability and improved efficiency.

This analysis proposes to replace PDVC billing (in the form of a cheque via the patient) with modernised gap-only billing arrangements featuring direct, electronic Medicare benefit payments to providers. Modernised gap-only billing would be limited to high cost services where the Medicare benefit component alone can amount to several thousands of dollars. Medicare benefit payments would be delayed by 90 days.

3.3.1. How modernised gap-only billing arrangements would work

In line with current gap-only billing arrangements (PDVC), under modernised gap-only billing arrangements patients would pay the gap component only of the provider's fee at the time of service. Patients would not have to pay the Medicare benefit component of the fee. For some Medicare items, the benefit amount can be several thousands of dollars.

Currently the Medicare benefit is sent to the provider indirectly – via the patient in the form of a cheque in the provider's name. Under modernised arrangements the Medicare benefit would be paid by Medicare directly

and electronically to the provider.

Under PDVC arrangements any Extended Medicare Safety Net benefits are currently paid to the patient or provider (depending on the out-of-pocket cost paid by the patient). Under modernised arrangements safety net payments would be paid to the patient in line with standard Medicare arrangements.

Under modernised arrangements the Medicare benefit payment to the provider would be delayed by 90 days (currently 60 days on average due to administrative processing of cheques). The reasons for this delay are detailed below.

Currently PDVC arrangements are available to all services (yet is used in less than 1% of all Medicare services). Modernised gap-only billing would be available for high cost services only (see rationale below). Gap-only billing arrangements would be available in services where the Medicare fee is greater than $697 (indexed annually).

Billing example for 'Medicare item 15926 - Radiation oncology planning':

Currently, the Medicare fee for this item is $7,215.40.

Commonly, the total costs for this radiation oncology service are around $10,000.

Under modernised gap-only billing the patient would be required to pay the gap amount only at the time of service (no change to existing PDVC arrangements).

The Medicare benefit component – currently $7,110.90 (85% of the MBS fee) – would be paid by Medicare directly and electronically to the provider after 90 days (currently paid via cheque under existing PDVC arrangements).

Any Extended Medicare Safety Net amounts would be paid directly to the patient.

3.3.2. Mitigating the risks of gap-only billing

Gap-only billing may encourage service price inflation and discourage bulk billing (see Section 1.1 Policy Problems). Policy measures designed to mitigate this include:

A. Confining gap-only billing to high cost services

Gap-only billing arrangements would be restricted to high cost medical services over $697. This price point is current at 1 November 2025 and would be indexed annually. Section 3.3.3 explains how a high cost service is defined.

Including lower-cost services in gap-only billing arrangements may expose these services to the risk of price inflation associated with split component billing (described in 1.1.3).

Additionally, gap-only billing is less likely to be attractive to providers for low cost services where bulk billing incentives are in place. From 1 November 2025 bulk billing incentives are available to providers for all GP non-referred attendances applicable to all patients regardless of age or concession card status. A GP bulk billing practice incentive program was also introduced on 1 November 2025 to provide additional funding to practices that commit to bulk bill all eligible services.

B. Specifying a significant delay to the payment of the Medicare benefit to the provider

Providers would receive the Medicare benefit component directly and electronically, delayed by 90 days. This delay is in line with existing arrangements where the payment is delayed by up to 90 days. The current average delay for a Medicare benefits cheque to be banked is 60 days. If the cheque has not been banked after 90 days an electronic payment is usually forwarded directly to the provider.

A significant payment delay to providers is likely to discourage overuse of gap-only billing where bulk billing could otherwise be offered. In contrast, the delay could also discourage the use of gap-only billing to the extent that the provider decides to charge the full fee.

On balance, reducing or removing the payment delay altogether from gap-only billing would likely encourage price inflation and discourage bulk billing.

3.3.3. Defining a 'high cost service'

A definition for 'high cost service' does not exist. In lieu of such a definition, it is proposed that a high cost service be defined as a service where the Medicare Schedule Fee is greater than $697 (at 1 November 2025, indexed annually). This price point is the Medicare fee where the greatest permissible gap (GPG) is applied. The GPG is a regulated amount which helps to regulate out-of-pocket costs for a single Medicare service. The fee at which the GPG applies ($697) is the only established price point within current Medicare arrangements which could act as a proxy to define a high cost service.

The $697 threshold would be indexed each year and would cover many surgical, radiation therapy, and diagnostic imaging services but would exclude lower cost services, including most GP and pathology services.

3.3.4. Implementing the same gap-only billing arrangements for all providers

All providers would be able to access gap-only billing, including allied health providers. The high cost service threshold and 90 day payment delay would apply in the same way to all providers.

3.3.5. Removal of PDVC arrangements from Child Dental Benefits Schedule (with no replacement gap-only arrangements)

PDVC arrangements would be removed from the Child Dental Benefits Schedule (CDBS) with no equivalent replacement. Gap-only arrangements are not required for CDBS given that 98% of CDBS services are bulk billed (no out-of-pocket costs). In 2024-25 dental providers claimed only $155,000 of benefits using PDVC billing across 2,250 services (an average of $68 per service). The impact on affordability of services for CDBS patients of not having the opportunity to pay the gap only would be negligible.

3.3.6. Reviewing modernised gap-only billing arrangements

Modernised gap-only billing arrangements would be monitored, with a review of the policy settings after three years.

3.3.7. Summary comparison of current and modernised arrangements

The following table summarises and compares the key features of current gap-only billing arrangements (PDVC) with modernised gap-only billing arrangements.

Feature	**Current gap-only billing arrangements (PDVC)***	**Modernised gap-only billing arrangements (Option 2)**
Payment by patient	Gap amount only, at time of service	Gap amount only, at time of service
Medicare claim	Submitted to Medicare by the patient (paper or electronic)	Submitted electronically to Medicare by the provider (no patient submission or paper option)
Medicare benefit payment	A cheque in the provider's name is posted from Services Australia to the patient to pass on to the provider. If the cheque is not banked within 90 days an electronic payment is transferred to the provider.	Direct electronic transfer to provider after 90 days
Medicare safety net	Included in the benefit cheque to the provider or paid directly to the patient	Direct electronic transfer to patient
Duration of delay of benefit payment to provider	Up to 90 days (average 60 days)	90 days
Eligible MBS items	All MBS items	Higher-cost services only, where MBS fee >$697 @1 Nov 2025 (indexed annually) representing approximately 30% of all MBS items

* See Appendix 1 for further background on current PDVC arrangements.

4. What is the likely net benefit of each option?

This section outlines the benefits and costs for each of the policy options proposed in this IA, including analysis of key impacts to stakeholders and a preliminary net benefit assessment of each option.

Option 1: Remove PDVC arrangements with no gap-only billing replacement.

Option 2: Replace PDVC arrangements with modernised gap-only billing arrangements.

As providers choose how to bill patients, the scope of these options extends to whether gap-only billing arrangements are needed and what those arrangements should look like. Other measures available to Government or providers to address affordability of fees are out of scope.

4.1. Option 1: Remove PDVC arrangements with no gap-only billing replacement

Impact on patients

Removing PDVC arrangements with no replacement would disadvantage patients whose providers choose to charge a gap rather than bulk bill. These patients would be required to pay the full fee at the time of service or seek alternative care.

Where providers chose to use PDVC arrangements during 2024-25, approximately 588,000 patients paid the gap amount only at the time of service. For those services 39,000 providers received $186 million in total in Medicare benefits via cheque. The average fee across all Medicare items is approximately $275 for non-concession card holders and $245 for concession card holders.

In the absence of gap-only billing arrangements, patients who are unable to afford the full fee may forgo their medical service or seek a public hospital service. Conversely, some providers who currently charge a gap under PDVC arrangements may instead choose to bulk bill these patients.

Impact on providers

If there are no gap-only billing arrangements, providers who currently bill using PDVC arrangements would be able to either charge the full fee (via patient billing) or accept the Medicare benefit alone as payment for the service (via bulk billing).

Providers who do not currently bill using PDVC arrangements would not experience any change.

Other impacts

Providers and patients would no longer incur the costs and administrative burden of managing cheques. Medical software suppliers may choose to remove this option from medical software.

The Government would incur financial and resource costs to remove cheques and associated payment systems and amend legislation. Other impacts such as physical or environmental impacts are not anticipated.

4.2. Option 2: Modernised gap-only billing for high cost medical services

Impact on patients

This option would improve service affordability for patients receiving high cost services where the provider chooses not to bulk bill.

Peak medical organisations have advised that some providers would offer gap-only billing to some of their patients who are currently charged the full fee at the time of service. This includes patients who are currently billed using PDVC arrangements.

The impact on CDBS patients of not implementing a gap-only billing arrangement is likely to be low due to very low use of current PDVC arrangements and high bulk billing rates.

Impact on providers

The impact of modernised gap-only billing arrangements on providers would be as follows:

- Providers who submit claims electronically would be able to use gap-only billing for high cost services. Providers who submit claims manually would not be able to use gap-only billing and would be able to bill using other options such as bulk billing or charging the full fee at the time of service.
- Providers who currently incur a debt if the patient fails to deliver the cheque would be able to use gap-only billing for high cost claims.
- Providers would not be required to use gap-only billing.
- While providers use PDVC arrangements for less than 1% of Medicare services representing less than 1% of the value of Medicare benefits, it is unknown whether providers would use modernised gap-only billing more or less than they currently use PDVC billing.

Patients and providers

Modernised gap-only billing arrangements would:

- Confer efficiencies in Medicare billing and payments by replacing cheques with EFT payments.
- Retain an option for providers to charge a gap amount only for high cost services.
- Preserve the attractiveness of bulk billing relative to gap-only billing by retaining a significant payment delay (90 days) after the claim is submitted before the Medicare benefit is sent to the provider. Currently cheques are banked on average after 60 days, with an EFT payment to eligible providers after 90 days if the cheque is not banked.

Impact on medical software suppliers

- Suppliers of medical software (used by providers or their staff when billing patients and claiming Medicare benefits) may choose to include gap-only billing in their medical software products.

Impact on government and government agencies

- Services Australia would not need to issue cheques.
- Government would incur financial and resource costs associated with removing cheques and associated payment systems and amending legislation. Both options would require amendment to legislation. The options would be subject to parliamentary scrutiny and require regulatory support to consider whether the goal of maintaining a gap-only billing option aligns with community needs and manages emerging risks. These processes would also provide a foundation for current and future Government policy initiatives to address any impacts of gap-only billing arrangements on providers and patients.

4.3. Multi-Criteria Analysis

There is insufficient data available to conduct a standard cost-benefit analysis. Instead, to inform the decision as to which option delivers the greatest net benefit, a multi-criteria analysis was conducted along with an estimation of the regulatory cost of each option.

The structured methodology of a multi-criteria analysis was selected as the most appropriate way of assessing and comparing options across multiple criteria. A multi-criteria analysis provides an efficient and flexible tool and is generally well-suited to public policy contexts.

The multi criteria analysis weighs up the extent to which the relative benefits of each option are likely to achieve the objectives to determine the option with the greatest net benefit. The decision rule is that the option with the highest net benefit is likely to be the best option for providers and patients. This analysis aims to quantify any significant costs and benefits based on the data available.

The attached table outlines both options and reflects the option with the greatest benefit in terms of the multi criteria analysis score.

The overall assumption is that for services where the provider uses gap-only billing for high cost services, patients benefit by not paying the full fee at the time of service.

For each objective, consideration has been given to the impacts of each option on the following stakeholders, external to Government, who are likely to be affected:

Patients seeking to access health care services to address their health needs

Providers of health care services who ensure good health outcomes for their patients whilst having regard to the viability of their associated practices

Medical software suppliers who may choose to include gap-only billing in their medical software products

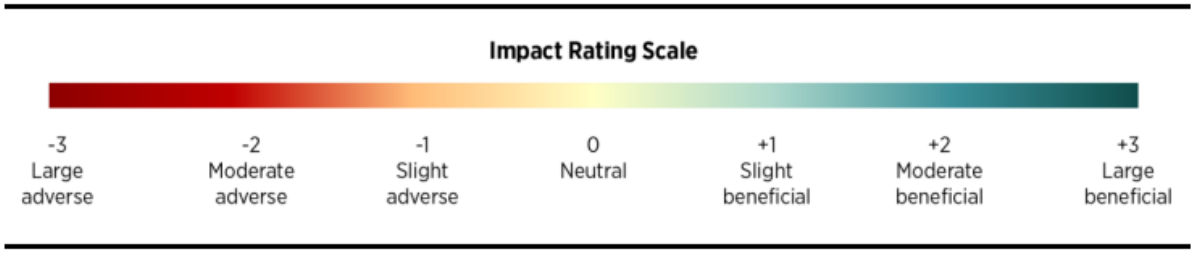
The likely impact of the proposed options on each identified stakeholder group were assessed, with consideration given to:

- How the proposed changes would impact the key identified stakeholders;
- Whether the options presented an increase, decrease, or no change to regulatory burden; and
- An assessment of the impact, using a common scale.

The scale chosen to be used for the assessment is a seven-point scale, indicating the anticipated impact of each option on the achievement of the objectives and impact on particular stakeholder groups. The seven-point scale ranges from -3 to +3 (with 0 representing no net change in benefit).

Changes which result in a beneficial impact, or reduced burden, have been rated as positive (green on Figure 1). Changes which increase operating costs or burden have been rated as negative (red on Figure 1). The neutral rating was used to signify minimal impact and that there would be no overall benefit or cost (yellow on Figure 1).

Figure 1 *Seven-point impact rating scale with -3 to -1 indicating an adverse impact, zero indicating no change (neutral), and +1 to +3 indicating a beneficial impact.*



The nominated values in the impact rating scale are intended to support easy interpretation of the ratings rather than representing a precise scale.

Table 1. *Benefits and likely achievement of each of the options in the context of the 4 objectives in Question 2 using the seven-point impact rating scale.*

Objective	Option 1: Removing PDVC with no replacement	Option 2: Modernised gap-only billing for high cost services	Comments
Objective 1 - Improve affordability and encourage bulk billing of health care services that are eligible for Medicare, for high cost services	0	+3	Option 1 would not achieve the first objective because patients who cannot afford the full fee up front would not be supported, if the provider chooses to charge them the full fee instead of bulk billing. There may be impacts on patient health outcomes and public sector waiting lists that cannot be measured quantitively for this IA. It is assessed that Option 1 achieves no benefit. Option 2 would ensure that an efficient 'gap-only billing' arrangement is available for any providers who wish to use it for high cost services, if the provider submits claims electronically. This would support patients if they cannot afford the full fee at the time of service. It is assessed that Option 2 achieves benefits.
Objective 2 - Improve Medicare billing efficiency, for high cost services	N/A	+3	Option 1 would not provide a gap-only billing arrangement through the Medicare payments system so is not applicable. Option 2 would pay Medicare benefits by EFT efficiently and effectively It is assessed that Option 2 achieves benefits.

Distributional Impacts

Option 1: Remove PDVC arrangements with no gap-only billing replacement

Under Option 1, all providers would be impacted equitably as all providers would continue to choose between bulk billing or patient billing the full fee at the time of service.

The impact on patients would be determined by the billing decisions of providers.

The 588,000 patients who are currently offered gap-only billing under PDVC arrangements (and therefore do not pay collectively the $186 million in Medicare benefits components of fees at the time of service) may be required by their providers to pay this component along with the gap component if they are charged the full fee at the time of service. This would lessen affordability which is likely to have a greater impact on those patients with less capacity to pay than on patients with readily accessible funds.

Some providers however may instead choose to bulk bill some of these patients, resulting in improved affordability for those with less capacity to pay the full fee at the time of service.

Option 2: Replace PDVC arrangements with improved gap-only billing arrangements

Under Option 2, all providers of high cost services would be impacted equitably as all providers would be able to use the gap-only billing arrangements if they claim electronically. If a provider chooses to use gap-only billing for patients who cannot afford the full fee at the time of service, those patients would benefit from the arrangements. The extent to which patients could benefit is dependent on the billing decisions of providers and cannot be estimated in this IA. Option 2 achieves the highest benefits for providers who wish to use gap-only billing to support patients for high cost services.

If providers choose to claim manually, they would not be able to bill using gap-only billing. Any unintended impact on providers who claim manually could be considered in a review.

Providers of low cost services (including general practice, allied health and pathology services) would not be able to bill using gap-only billing. The impact on patients would be determined by billing decisions of providers. Low cost services are inherently more affordable.

Limitations on considering the most effective options

The Medicare data available about claims by providers under PDVC arrangements is not necessarily indicative of whether gap-only billing would be used by providers.

Medicare data does not demonstrate why providers bill using PDVC arrangements, as providers chose how they bill patients.

Medicare data is not intended to show the extent to which patients can afford the full fee or the gap fee only. Data from other sources may be discovered during a review.

Monetized Regulatory Impact

Regulatory burden estimate (RBE) table

Option 1 Removing PDVC arrangements without a replacement

It is anticipated that removing PDVC arrangements with no replacement would result in a 'regulatory' saving (reduced administrative burden) for providers and patients. Any cost for medical practice software suppliers to change medical software may be minor (and would be discovered during consultation).

Impacts on government agencies are not included in these tables.

These are departmental estimates. Please see 'New labour cost' section further below for calculations.

Providers

(A) Providers would no longer manage cheques– average annual regulatory cost of -$3.7m (ie. saving)

Average annual regulatory costs				
Change in costs ($ million)	Individuals	Business (providers)	Community organisations	Total change in cost
Total, by sector	$0	-$3.7m	$0	-$3.7m

Patients

(B) Patients would no longer deliver cheques – average annual regulatory cost of -$8m (ie. saving)

Average annual regulatory costs				
Change in costs ($ million)	Individuals	Business (providers)	Community organisations	Total change in cost
Total, by sector	-$8m	$0	$0	-$8m

Total

(B+C) The total average annual regulatory costs are therefore:

Average annual regulatory costs				
Change in costs ($ million)	Individuals	Business (providers)	Community organisations	Total change in cost
Total, by sector	-$8m	-$3.7m	$0	-$11.7m

Option 2 Gap-only billing for high cost services

Providers are not required to use PDVC arrangements and would not be required to use modernised gap-only billing arrangements. Providers can choose other billing options, including bulk billing or charging the full fee at the time of service.

This option would incur the same savings for providers and patients as under option 1, but may also incur some set up costs for medical software suppliers if they choose to include gap-only billing in medical software. Please see 'New labour cost' section further below for calculations.

Providers and medical software providers

It is anticipated that providers would experience the same savings as outlined in option 1 from not managing cheques. Medical software suppliers may incur set up costs to change PDVC billing to gap-only billing for high cost services. Any costs advised by medical software suppliers during consultations will be included in the tables below and considered in the benefits analysis in the final IA. Providers and practice staff may incur minor set up costs represented by time for training to submit claims through gap-only billing, which may be balanced by ongoing time savings in no longer managing cheques. Providers would no longer need to follow up with patients who do not deliver cheques. Any costs above those included in the tables are minor and are not known at this stage.

Patients

It is estimated that patients would experience the same savings as outlined in option 1 from not managing cheques.

(A) Providers would no longer manage cheques – average annual regulatory cost of -$3.8m (ie. Saving)

Average annual regulatory costs				
Change in costs ($ million)	Individuals	Business (providers)	Community organisations	Total change in cost
Total, by sector	$0	-$3.7m	$0	-$3.7m

Patients

It is estimated that providers would experience the same savings as outlined in option 1 from not delivering cheques.

(B) Patients would no longer deliver cheques – average annual regulatory cost of -$8m (ie. Saving)

Average annual regulatory costs				
Change in costs ($ million)	Individuals	Business (providers)	Community organisations	Total change in cost
Total, by sector	-$8m	$0	$0	-$8m

Total

(B+C) The total average annual regulatory costs are therefore:

Average annual regulatory costs				
Change in costs ($ million)	Individuals	Business (providers)	Community organisations	Total change in cost
Total, by sector	-$8m	-$3.7m	$0	-$11.7m

New labour cost

It is estimated that 50% of PDVC patients post their cheques and 50% hand deliver them to their provider. Those who hand deliver the cheque at their next visit are likely to experience negligible administrative burden. For those who post their cheques the average time taken to post the cheque is estimated at 30 minutes.

The average time taken for a provider to include the cheque in their next visit to a financial institution and have it deposited is estimated at 3 minutes.

The following calculations of the net benefit of electronic gap-only billing are based on the above estimates.

Patients

(Time saved = **30 minutes per Medicare service by 50% of PDVC patients to no longer manage cheques)**
× Labour cost **$37 per hour** as set out in the Regulatory Burden Measurement Framework (February 2024))
× Times performed **870,000 claims per year** (Medicare data)
× Number of patients **(n/a as included in the claims)**
Annual cost = 0.5 hrs x $37/hr x (870,000/2) = $8,047,500 rounded to $8.0 million
10 year cost = $80 million

Providers

(Time required **3 minutes per Medicare claim by a provider (or their staff) to no longer manage cheques)**
This assumes that providers receive a cheque, bank a cheque and follow up with any patients who do not deliver a cheque. Providing receipts to patients not anticipated to change.
× Labour cost **$85.17 per hour** as set out in the Regulatory Burden Measurement Framework (February 2024))

× Times performed **870,000 claims per year** (Medicare data)
× Number of providers **(n/a as included in the claims)**
= 3 minutes/60 minutes x $85.17 x 870,000 = $3,705,000 rounded to $3.7 million
x 10 years = $37 million

Note: The benefits to providers and patients of access to a gap-only billing arrangement are not quantifiable.

Greatest Net Benefit

Based on the above considerations including regulatory impact costings, seven-point multi-criteria analysis, and noting the equity of impact, Option 2 was found to have the greatest net benefit.

Patients who cannot afford high cost services are likely to experience improved affordability at the time of service if providers choose to charge a gap and use modernised gap-only billing arrangements.

Option 2 would deliver gap-only billing arrangements for providers who wish to charge a gap and use modernised arrangements to support patients.

Option 2 would save patients and providers over $11 million annually in regulatory costs of managing cheques.

Appendix 1

How providers bill using PDVC arrangements

- If a provider chooses to bill a patient using PDVC arrangements then the patient pays only the gap amount (nil, some or all the gap amount) at the time of service.
- The provider informs the patient that a Medicare cheque will be sent to the patient, and the patient requests that the Medicare benefit is assigned to the provider.
- The provider (or patient) submits the claim to Medicare.
- If the patient has not yet paid all of the gap amount, the provider and patient agree to a payment arrangement, and the patient can advise Medicare when the patient later pays the rest of the gap amount (as this may contribute to the patient's Extended Medicare Safety Net benefit entitlement).
- Medicare assesses the claim. If eligible, Medicare issues a cheque made in the name of the provider for the amount of Medicare benefit - Medicare sends the cheque to the patient, as Medicare is a patient entitlement.
- If the patient is entitled to Extended Medicare Safety Net benefit for this claim, the benefit may be paid to either the patient or in the cheque for the provider, depending on the gap fee paid at the date of claim.
- The patient forwards the cheque to the provider, and the provider issues a receipt.
- If the cheque is not banked after 90 days, Medicare cancels the cheque and pays the Medicare benefit by EFT to the provider. Some providers do not have access to electronic payments and are required to follow up with the patient.
- Further information on PDVC arrangements can be found on the Services Australia website via the following link: 90 day pay doctor cheque scheme - Health professionals - Services Australia