EXPLANATORY STATEMENT

Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024

Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025

The *Health Insurance Act 1973* (the Act) sets out the principles and definitions governing the Medicare Benefits Schedule (MBS), this includes for payments by way of Medicare benefits and for other purposes. In July 2024, the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024* (AoB Act) was passed, amending the Act to modernise and strengthen the 'assignment of Medicare benefit' requirements for bulk billed and simplified billing services. The amendments update statutory requirements to align with current industry practices and better enable assignment using digital technologies.

Subsection 133(1) of the Act provides that the Governor General may make regulations, not inconsistent with the Act, prescribing all matters required or permitted by the Act to be prescribed, or necessary or convenient to be prescribed for carrying out or giving effect to the Act.

The creation of this instrument relies on Section 4 of the *Acts Interpretation Act 1901*.

Purpose

The *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025 (amending Regulations)* will support amendments introduced in the AoB Act to modernise the assignment of benefits process. Specifically, these amending Regulations will ensure that meaningful information is provided to an assignor and that evidence of the authority for government payments is retained by claimants of assigned benefits. The *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025* amends the *Health Insurance Regulations 2018*.

Assignment of benefit for bulk billed and simplified billing services is the process through which eligible persons may enter into an agreement with a health service provider to assign their right to payment of a Medicare benefit.

Bulk billing assignment agreements

Regulatory amendments provide for bulk billing assignment agreements:

- the 'data set' a medical provider must give an assignor to inform an assignment decision. It is designed to provide meaningful information to an assignor, some of which is common to claiming but is otherwise shorter and simpler;
- the data set is specified based on the category of services and whether it is used to create an assignment of benefit agreement to be made before a professional service (pre-assignment), or after (post-assignment), on a per-service basis (episodic);
- that if pre-assignment agreements are rendered invalid, a post-services assignment is required; and,
- that an assignment agreement must be made in writing (including electronic or digital forms) but does not need to be of a specific approved form or format. A patient's signature is required to indicate their agreement of a form sufficient to satisfy the *Electronic Transactions Act 1999* (i.e. to identity the person and indicate the person's intention in respect of information communicated).

Simplified billing assignment agreements

Regulatory amendments provide for simplified billing assignment agreements for hospital and hospital-substitute treatment covered under a complying health insurance policy:

- the information that must be provided to an assignor prior to an assignment request or before an assignment request is modified for simplified billing;
- three methods by which benefits can be taken to be pre-assigned under new subsections 20AAA(1), (3) or (5) of the Act, with the benefit taken to be assigned once a claim for the benefit has been made under new subsections 20AAA(2), (4) or (6) of the Act; and
- the manner, content, and form of the notification that is provided to the assignor in relation to the assignment and assigned Medicare benefit.

Claims for Medicare benefits assigned as part of simplified billing

Regulatory amendments provide claiming requirements when assignments are made by an eligible person who holds a complying health insurance policy with a private health insurer.

Record-keeping requirements for bulk billed services

Regulatory amendments specify that claimants of an assigned benefit for a bulk billed service must retain a copy of the relevant assignment agreement, for the purposes of subsection 127A(1) of the Act.

Notification and record keeping requirements for simplified billing

Regulatory amendments specify:

- the circumstances an insurer or approved billing agent must provide the assignor a notification of the payment of the assigned Medicare benefit, for the purposes of subparagraph 127(3)(d)(i) of the Act, and its contents;
- that the responsible provider must notify an assignor of a modification of a request, for the purposes of subparagraph 127(5)(d)(i) of the Act;
- the manner and form of the notification;
- the records that must be retained by a private health insurer or approved billing agent, for the purposes of subsection 127A(1) of the Act, for benefits assigned under subsection 20A(2) of the Act, including notifications made under paragraph 127(3)(d) of the Act;
- the records that must be retained by an operator of a hospital, an organization or a professional under subsection 127A(3) of the Act, in relation to eligible hospital treatment (see subsection 20AAA(7) of the Act), for benefits assigned under subsection 20A(2) of the Act; and,
- the duration that records must be retained for the purposes of paragraph 127A(5)(c) of the Act.

Change to heading

The heading of Division 5 Part 3 of the *Health Insurance Regulations 2018* will be amended to reflect the separation of particulars required for a benefit to be payable, that is for an account or receipt in relation to a professional service, from those required for assignment of a Medicare benefit under new Division 7.

Privacy considerations

The amending Regulations include requirements relating to the use and disclosure of personal information and new requirements for health professionals, insurers, billing agents, the operator of a hospital or an organization to retain certain records containing personal information. This could include sensitive personal information such as information about medical treatments a patient receives.

The personal information required to be provided to Services Australia as part of a claim for Medicare benefit will largely be unchanged. The effect of the regulations is simply to include a new power allow the *Health Insurance Regulations 2018* to specify the information required to be included as part of a claim for Medicare benefit made under section 20B of the Act, rather than this information being required to be included in a claim as part of the form for making a claim or the manner of making the claim.

There is no change to the personal information required to be included in the patient account or receipt under subsection 19(6) of the Act.

The amending Regulations will not increase the amount of personal information required to for an assignment agreement. The amending Regulations will remove the need for assignment agreements to include all the particulars specified for subsection 19(6) and focus on only key information relevant for a person who is considering making an assignment agreement or who has made such an agreement, in a format that will be more meaningful to them.

Amendments to the Act establish record keeping requirements for relevant parties to retain copies of assignment agreements and supporting documents that substantiate an assignment for a period of two years, or another period set in the Regulations. The amending Regulations specify a longer record retention period for Medicare benefits assigned under subsection 20A(2) of the Act, to accommodate the following:

- period of time for a simplified billing claim to be made from the date set out in the assignment request as per 65D(1) of the Regulations or from the date of service;
- period of time for a late claim to be approved and from the date set out in the assignment request as per 65D(1) of the Regulations or from the date of service;
- period of time for an adjustment to the claim made for a professional service;
- period of time for a notification to be made to the assignor; and
- period of time for government compliance activities once payment for an assigned Medicare benefit has been made.

The requirement for health professionals, insurers, billing agents, the operator of a hospital or an organization to retain relevant records will support the government's capacity to undertake compliance activities to protect Commonwealth expenditure on Medicare services and ensure that Medicare benefits otherwise payable to patients is only assigned to other persons in accordance with the Act.

Entities are required to take reasonable steps to destroy or de-identify these records, in line with the Australia Privacy Principles, where it is no longer required for the purposes of an assignment of benefit made under subsection 20A and 20AAA of the Act and the amending Regulations, and where it is not required under another Commonwealth law to retain the information.

The notification requirements provide the assignor with assurance and transparency regarding Medicare benefits that they have assigned, or taken to be assigned, and which has been received on their behalf.

The Chief Executive Medicare separately has the power under subsection 129AAD of the Act to compel a person to produce these records if relevant to determining whether a Medicare benefit has been incorrectly paid.

The amending Regulations reduce the volume of information required to evidence an assignment agreement and does not require the inclusion of any additional sensitive health information. Amending Regulations echo existing powers under the Act, which are necessary to enable compliance activities to administer the integrity of Medicare payments, including for bulk billed and simplified billing.

Consultation

The development of the *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025* has been informed by extensive engagement with stakeholders, including interagency discussion with Services Australia and advice from the Australian Government Solicitor.

Department of Health, Disability and Ageing (the department) consulted key stakeholders, including medical industry and consumer representatives, hospitals, private health insurers, jurisdiction state/territory health departments and software providers, regarding the scope, content and purpose of regulations to support legislative amendments to the assignment of benefits process.

Since July 2024 the department has provided 42 external stakeholder consultations involving 132 stakeholder organizations, including:

- 28 public hospitals representatives, including jurisdictional governments
- 30 medical industry peak bodies
- 25 Aboriginal Community Controlled Health Organisations (remote locations)
- 30 medical industry software vendors
- 12 peak consumer groups
- 7 private health insurance organizations

In February 2025, the department published the *Consultation on Assignment of Medicare Benefits for Simplified Billing Services* discussion paper and received 20 formal submissions. A public information session was attended by representatives from 38 organizations.

All stakeholders have voiced support for modern and simplified assignment of Medicare benefits processes, noting comprehensive education and communication is required to ensure that providers and patients are aware of and understand their roles and responsibilities.

Details of the Regulations are set out in the Attachment.

The Act specifies no conditions that need to be satisfied before the power to make the amending Regulations may be exercised.

The amending Regulations are a legislative instrument for the purposes of the *Legislation Act 2003*.

The Regulations will commence immediately after the commencement of Schedule 1 to the AoB Act.

Authority: Subsection 133(1) of the *Health Insurance Act 1973*

ATTACHMENT

Details of the *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025*

Section 1 – Name

This section provides for the Regulations to be referred to as the *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025* (the Regulations).

Section 2 – Commencement

The Regulations will commence immediately after the commencement of Schedule 1 to the AoB Act.

Section 3 – Authority

This section provides that the Regulations are made under the *Health Insurance Act 1973* (the Act).

Section 4 – Schedules

This section 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.

Health Insurance Regulations 2018

Item [1] – Section 4
This item provides terms for types of assignment of benefit agreements, and identifies the subsection which provides the relevant definition.

Item [2]
After Division 7 of Part 3
This item establishes that meeting requirements of the Act for bulk billed services must be an episodic (per service) agreement as specified. This can be entered into, before or after a professional service is rendered but must be in writing.

Section 65A
This section establishes a simplified outline of Division 7 and the powers within the Act which permit the proposed regulations.

Section 65B
This section provides that for the purposes of paragraph 20A(1)(d) of the Act, the agreement must be an episodic agreement that meets the requirements of the proposed regulations.

Subsection 65C(1)
This subsection outlines that for the purposes of section 20A(1)(d) of the Act, Section 65C specifies the requirements that must be met for an episodic agreement.

Subsection 65C(2)
This subsection defines an episodic agreement (for bulk billing) under subsection 20A(1) of the Act.

Subsection 65C(3)
This subsection outlines and defines the two types of episodic agreements, being an episodic pre-agreement and an episodic post-agreement.

Subsection 65C(4)
This subsection outlines the 'data set' that the professional is required to give to the assignor in writing, before either party offers entry into an episodic agreement.

Paragraph 65C(4)(a)
This paragraph outlines that an episodic agreement must include the name of the person to whom the agreement service is or will be rendered.

Paragraph 65C(4)(b)
This paragraph outlines that an episodic agreement must include the date at which the agreement is proposed to be entered into.

Paragraph 65C(4)(c)
This paragraph outlines that an episodic agreement must specify whether the agreement is an episodic pre-agreement or an episodic post-agreement.

Paragraph 65C(4)(d)
This paragraph outlines a table containing items 1-6 with 2 columns. Column 1 specifies the kind of agreements and column 2 outlines the information required for the purpose of an episodic agreement.

Subsection 65C(4)(d) (table item 1, column 1)
This item specifies that for an episodic pre-agreement relating to a pathology service (other than Group P9), the information in item 1, column 2 must be given to the assignor in writing before either party offers entry into an episodic agreement.

Subsection 65C(4)(d) (table item 1, column 2, paragraph a)
This item outlines that for an episodic pre-agreement relating to a pathology service (other than Group P9), the date on which the specimen is or was collected must be specified in the agreement.

Subsection 65C(4)(d) (table item 1, column 2, paragraph b)
This item outlines that for an episodic pre-agreement relating to a pathology service (other than Group P9), a description of the service that would be understood by the medical practitioner and sufficient to identify the item in the pathology service table must be specified in the agreement.

Subsection 65C(4)(d) (table item 1, column 2, paragraph c)
This item outlines a statement to the effect that entry into an episodic pre-agreement relating to a pathology service (other than Group P9) also constitutes the assignor's agreement to assign their right to the payment of Medicare benefit to the professional for a pathologist-

determinable service, must be specified in the agreement. A determinable service is one that is rendered by an approved pathology practitioner or on their behalf and is clinically necessary.

Subsection 65C(4)(d) (table item 2, column 1)
This item specifies that for an episodic post-agreement relating to a pathology service (other than Group P9), the information in item 2, column 2 must be given to the assignor in writing before either party offers entry into an episodic agreement.

Subsection 65C(4)(d) (table item 2, column 2, paragraph a)
This item outlines that for an episodic post-agreement relating to a pathology service (other than Group P9), the particulars prescribed in subsection 54(2) must be specified in the agreement.

Subsection 65C(4)(d) (table item 2, column 2, paragraph b)
This item outlines that for an episodic post-agreement relating to a pathology service (other than Group P9), the date on which the specimen was collected must be specified in the agreement.

Subsection 65C(4)(d) (table item 2, column 2, paragraph c)
This item specifies that for an episodic post-agreement relating to a pathology service (other than Group P9), the item number in the pathology service table of the rendered service must be specified in the agreement.

Subsection 65C(4)(d) (table item 3, column 1)
This item specifies that for an episodic pre-agreement relating to a diagnostic imaging service, the information in item 3, column 2 must be given to the assignor in writing before either party offers entry into an episodic agreement.

Subsection 65C(4)(d) (table item 3, column 2, paragraph a)
This item outlines that for an episodic pre-agreement relating to a diagnostic imaging service, the date on which the diagnostic imaging procedure to be undertaken must be specified in the agreement.

Subsection 65C(4)(d) (table item 3, column 2, paragraph b)
This item outlines that for an episodic pre-agreement relating to a diagnostic imaging service, a description of the service sufficient to identify the item in the diagnostic imaging service table must be specified in the agreement.

Subsection 65C(4)(d) (table item 3, column 2, paragraph c)
This item outlines a statement to the effect that entry into an episodic pre-agreement relating to a R-type diagnostic imaging service also constitutes the assignor's agreement to assign their right to the payment of Medicare benefit to the professional for a diagnostic imaging service within the meaning of section 16B of the Act, must be specified in the agreement. An eligible R-Type diagnostic imaging service is one that has been deemed clinically necessary and more appropriate than the initially agreed service or services.

Subsection 65C(4)(d) (table item 4, column 1)
This item specifies that for an episodic post-agreement relating to a diagnostic imaging service the information in item 4, column 2 must be given to the assignor in writing before either party offers entry into an episodic agreement.

Subsection 65C(4)(d) (table item 4, column 2, paragraph a)
This item specifies that for an episodic post-agreement relating to a diagnostic imaging service, one or more of the identifying details of the professional (in subsection 65(5)) who has rendered the service must be specified in the agreement.

Subsection 65C(4)(d) (table item 4, column 2, paragraph b)
This item specifies that for an episodic post-agreement relating to a diagnostic imaging service, the date on which the diagnostic imaging procedure was undertaken must be specified in the agreement.

Subsection 65C(4)(d) (table item 4, column 2, paragraph c)
This item specifies that for an episodic post-agreement relating to a diagnostic imaging service, the item number in the diagnostic imaging service table of the rendered service must be specified in the agreement.

Subsection 65C(4)(d) (table item 5, column 1)
This item specifies that for an episodic pre-agreement not relating to items 1 to 4 (pathology (other than Group P9) and diagnostic imaging services), the information in item 5, column 2 must be given to the assignor in writing before either party offers entry into an episodic agreement.

Subsection 65C(4)(d) (table item 5, column 2, paragraph a)
This item specifies that for an episodic pre-agreement relating to all other services not included in items 1 to 4, one or more of the identifying details of the professional (in subsection 65(5)) who will render the service must be specified in the agreement.

Subsection 65C(4)(d) (table item 5, column 2, paragraph b)
This item specifies that for an episodic pre-agreement relating to all other services not included in items 1 to 4, the date on which the service will be rendered must be specified in the agreement.

Subsection 65C(4)(d) (table item 5, column 2, paragraph c)
This item specifies that for an episodic pre-agreement relating to all other services not included in items 1 to 4, a basic service description (under Health Insurance Regulations 2018 – Basic Service Description for Assignment of Medicare Benefits as in force on the day the regulations commence) of the service that will be rendered must be specified in the agreement.

The intention is to map all MBS items to a category which provides a simplified description, for use in pre-assignment agreements. Basic Service Descriptions based on a hierarchy of service characteristics will be meaningful for the assignor, noting that pre-assignment agreements are made before such time as a specific MBS item number or service description is known.

Subsection 65C(4)(d) (table item 6, column 1)
This item specifies that for an episodic post-agreement not relating to items 1 to 4 (pathology (other than Group P9) and diagnostic imaging services), the information in item 6, column 2 must be given to the assignor in writing before either party offers entry into an episodic agreement.

Subsection 65C(4)(d) (table item 6, column 2, paragraph a)
This item specifies that for an episodic post-agreement relating to all other services not included in items 1 to 4, one or more of the identifying details of the professional (in subsection 65(5)) who has rendered the service must be specified in the agreement.

Subsection 65C(4)(d) (table item 6, column 2, paragraph b)
This item specifies that for an episodic post-agreement relating to all other services not included in items 1 to 4, the date on which the service was rendered must be specified in the agreement.

Subsection 65C(4)(d) (table item 6, column 2, paragraph c)
This item specifies that for an episodic post-agreement relating to all other services not included in items 1 to 4, the item number in the general medical service table or pathology service table of the rendered service must be specified in the agreement.

Subsection 65C(5)
This subsection specifies that for the purpose of items 4-6 in the table under subsection 4, the identifying details of the professional are:

- the name of the professional and address of the place of practice; or
- the provider number of the professional.

Subsection 65C(6)
This subsection specifies the information required for an episodic agreement which must:

- contain the information in subsection 65C(4); and
- specify whether or not the assignor of the agreement is the person who will or has received a service; and
- be a written document; and
- be signed by the assignor.

Subsection 65D(1), (2), and (3)
This item relates to an assignment request mentioned in subsection 20AAA(3) of the Act. This item sets out the manner, content, and form of the information that must be given by the responsible provider (either an operator of the hospital, organization, or health professional) to the assignor before the assignor makes a request to assign their benefit to their private health insurer or an approved billing agent.

The information in subsection 65D(1) must be provided to the assignor in writing and the assignment request by the assignor must also be made in writing, as per paragraph 65D(3)(b). This information should be provided to the assignor prior to professional services being rendered but can be provided after.

A single assignment request can facilitate the assignment of multiple professional services by multiple health professionals. This applies if the professional services are covered by the particulars (i.e., description of the condition, treatment, or services (to be) rendered) and the

health professional/s covered by the assignment are authorised to provide hospital or hospital-substitute treatment as per subsection 20AAA(7) of the Act.

As a guide, the responsible provider can cover majority of the prescribed particulars with the following wording to facilitate and demonstrate the assignor's request to assign their right to a Medicare benefit/s:

For assignment requests facilitated by the operator of the hospital or organization:

> I assign my right to Medicare benefits to [*name of private health insurer* / *approved billing agent to whom the benefit/s are to be assigned to*] in respect of any professional services provided [to me / to *name of patient*] as part of [hospital treatment / hospital-substitute treatment] relating to [*description of condition/treatment/services*][and including any associated pathology, diagnostic imaging and referred professional services (*if applicable*)] provided by or on behalf of [health service professionals or *refer to list of names of health professional/s*] authorised by [*name of responsible provider*] at [*location where the professional service will be/was rendered*] [during my / *name of patient*'s*)* admission commencing *date of admission* / rendered on *date of service*].

For assignment requests facilitated by a health professional for hospital-substitute treatment:

> I assign my right to Medicare benefits to [*name of private health insurer* / *approved billing agent to whom the benefit/s are to be assigned to*] in respect of any professional services provided [to me / to *name of patient*] as part of hospital-substitute treatment relating to [*description of condition/treatment/services*] provided by or on behalf of [*name of health professional*] at [*location where the professional service will be/was rendered*] rendered on [*date of service*].

The responsible provider, or authorised persons, can set out the particulars in other written formats. The above wording aims to standardise how the particulars are presented to the assignor in a way that is meaningful and demonstrates a clear intent to assign their right to a Medicare benefit. The name of the person to whom the professional service was or will be rendered (either the name of the assignor or, if different to the assignor, the name of the patient), information relating to the complying health insurance policy (CHIP), and to whom the request is being made to is not specifically included in the above wording but must be included in the assignment request.

In the Act and for the purposes of these Regulations, a hospital is a facility for which a declaration under subsection 121-5(6) of the *Private Health Insurance Act 2007* is in force: see subsection 3(1) of the Act and subsection 121-5(5) of the *Private Health Insurance Act 2007*.

Paragraph 65D(1)(d) and subsection (2)

This item specifies that, if the assignment request is made to the operator of the hospital or the organization, the information they provide to the assignor can either:

- list the name of each professional who is authorised by the operator of the hospital to provide services during the assignor or patient's hospital treatment, or
- list the name of each professional who is authorised by the organization to provide services during the assignor or patient's hospital-substitute treatment, or

- include a statement by the operator of the hospital or the organization that health professionals they have authorised to provide services during the assignor or patient's hospital or hospital-substitute treatment is covered by the assignment request.

If the assignment request for hospital-substitute treatment is made to a health professional, the name of the health professional must be included in the information provided to the assignor.

Paragraph 65D(1)(e)
This paragraph sets out the requirement for the date of admission or date of service that must be included in the information provided to the assignor.

Under subparagraph 65D(1)(e)(i), the date of admission is generally accepted to be the date from which hospital treatment episode of care will commence. As such, only professional services rendered on or from that stated date, rendered within that episode of hospital treatment and covered by the description in paragraph 65D(1)(f), are covered by the assignment request.

Otherwise, under subparagraph 65D(1)(e)(ii), the date of service, applicable to professional services rendered as part of hospital or hospital-substitute treatment, can be stated.

Paragraph 65D(1)(f)
This paragraph specifies the requirement for a description of the hospital or hospital-substitute treatment during which the professional service was or will be rendered. This can include a general description of the condition the assignor or patient will be treated for, the treatment that will be provided to the assignor or patient, and/or the services that will be rendered to the assignor or patient during the episode of hospital or hospital-substitute treatment.

For cardiac-related hospital treatment, an example of a description to satisfy the requirements of paragraph 65D(1)(f) could state: "the investigation and treatment of heart, heart-related conditions and vascular system, including any associated pathology, diagnostic imaging and referred professional services".

Paragraph 65D(1)(g)
This paragraph requires 'name of the person to whom the right to payment of the Medicare benefit will be taken to be assigned'. Consistent with subsection 20AAA(4) of the Act, this refers to the name of the private health insurer or the approved billing agent.

Paragraph 65D(1)(h)
This paragraph requires the location where the professional service was or will be rendered.

For subparagraph 65D(1)(h)(i), the name of the hospital should include sufficient detail that the hospital can be identified. In instances where a hospital has the same name as another hospital, the suburb where the hospital is located should be included to accurately establish where the hospital treatment was or will be rendered.

Subsection 65D(4) and (5)
This item sets out the manner, content, and circumstances for an assignment request, mentioned in subsection 20AAA(3) of the Act, to be modified by a responsible provider.

Prior to an assignment request being modified, the responsible provider must provide the assignor with a written, revised version of the request (i.e., the information set out in subsection 65D(1) of these Regulations) and obtain written approval from the assignor to so modify the request.

As per subsection 20AAA(3)(b) of the Act, modifications to an existing assignment request is required if the *new professional service* has already been rendered. The *new professional service* must also have been provided during the same episode of hospital treatment or on the same date of service (whichever is relevant to the existing assignment request). If a professional service is not covered by an existing assignment request and is yet to be rendered, a new assignment request is required, which can replace the existing request.

A modification to an assignment request is not required if a professional service is taken to be assigned under subsection 20AAA(1) ('implied assignment' or assignment by operation of law) or subsection 20AAA(5) (assignments for complications and related urgent unplanned services) of the Act.

Division 7B, section 65E
This item sets out the requirements for a Medicare claim under section 20B of the Act and includes a new requirement under subsection 65E(c) for services that are taken to be assigned under subsection 20A(2) of the Act (simplified billing services).

Subsection 65E(c) specifies a new requirement for the person making the claim for Medicare benefits (either the hospital, health professional, organization, or approved billing agent) to attest that they have satisfied the assignments requirements of paragraphs 20A(2)(a) to (c) and (e) of the Act in making that claim. For example, this means that if a Medicare benefit for a professional service is assigned under subsection 20AAA(3) of the Act, the responsible provider has facilitated the assignor's request to assign their right to a Medicare benefit. This includes providing the assignor with the information set out in subsection 65D(1) of the Regulations and obtaining the assignor's written approval.

Item [3]
Division 1A, Subdivision A, section 89A
This section sets out the kind of records that must be kept by a professional under subsection 127A(1) of the Act.

Division 1A, Subdivision B, section 89B
This item sets out the notification manner, content, and form for Medicare benefits assigned under subsection 20A(2) of the Act (simplified billing services).

Sections 89C and 89D
These sections sets out the record-keeping and record retention requirements by the following: the private health insurer, the approved billing agent, the operator of the hospital, the organization, and the health professional. Records that evidence compliance with the requirements of the Act and the regulations are required to be kept by the relevant party.

Item [4] – Division 5 of Part 3 (heading)
This item repeals the existing heading and substitutes it with a new heading to correctly identify what the Division relates to following the restructure.

Item [5] – Section 47
This item omits all words from and including “on:” to and including “in relation to the professional service”.

Item [6] – Section 47
This item omits “particulars for the purposes of subsection 19(6) of the Act”, substitute “those particulars”.

Item [7]
Division 2 Part 12
This item inserts Division 2 outlining the application, saving and transitional provisions relating to the proposed regulations.

Section 104
This section defines commencement day which is the day the Division commences.

Section 105
This section outlines the application provisions for offers related to pathology services made before the commencement date.

Statement of Compatibility with Human Rights

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

Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025

This Regulation 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 Disallowable Legislative Instrument

The *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025 (the Regulations)* will support amendments introduced in the AoB Act to modernise the assignment of benefits process.

The Regulations implement changes to the *Health Insurance Regulations 2018* to specify the content of assignment of Medicare benefit agreements. The agreements are presented to inform an assignor's decision whether to enter an agreement with a practitioner for a professional service (bulk billing assignments), or an insurer or billing agent (for a simplified billing assignment) and outline the acceptable signature requirements. The proposed Regulations will specify the record keeping requirements and assignment of benefit declaration requirement for providers making a claim for payment of simplified billing Medicare benefits.

The *Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025* will amend the *Health Insurance Regulations 2018 (HIR)* to:

- separate the particulars for an assignment of benefit agreement from those used for an account and receipt for the professional service;
- specify the requirements for an episodic agreement to suit clinical scenarios and whether it is presented to the assignor before or after a service;
- specify the kind of records that must be kept by a professional who enters into an agreement under subsection 20A(1) and (2) of the AoB Act and makes a claim for the Medicare benefit under section 20B of the Act.
- specify the information that must be provided to an assignor prior to an assignment request or before an assignment request is modified as per subsection 20AAA(3) of the AoB Act.
- set out the manner, content, and form of the notification that is provided to the assignor in relation to the assignment and assigned Medicare benefit.
- require providers to attest that legislated assignment requirements are satisfied in making a claim for an assigned Medicare benefit.

Human rights implications

The Regulations engage 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

The Regulations maintain the rights to health and social security and the right of equality and non-discrimination by ensuring access to publicly subsidised medical services are clinically and cost-effective as intended.

The Regulations improve the governing framework for the payment of Medicare benefits in the interests of consumers and improve the information provided to consumers to allow them to make more informed choices.

Modernising assignment of Medicare benefits simplifies and streamlines the administration of Medicare claiming while better ensuring payment integrity. Patients and practitioners will find it easier to use and provide Medicare services respectively and make lawful claims for services that maintain patients' health.

The amending regulations update the foundations for 'bulk billed' Medicare services and 'simplified billing' of privately insured hospital and hospital substitute treatment, both of which enable healthcare to be provided at no cost or reduced cost to patients.

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. It does not raise any human rights issues.

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